

CLINICAL PSYCHOLOGY

By Charles Berg

WAR IN THE MIND
DEEP ANALYSIS

CLINICAL PSYCHOLOGY

*A Case Book of the Neuroses
and their Treatment*

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SECTION I
FROM MEDICINE
TO MIND

CHAPTER I

A CLINICAL ODYSSEY

AUTOBIOGRAPHICAL

To what extent can education, or the reading of such a book as this, effect any important change in a person's nature, character and outlook? After all, phylogenetically the individual extends back a thousand million years or more and, if we admit no break, as I believe, between the biosphere and the cosmo-sphere, we may extend him back to essential electronic energy or the cosmic curvature of space time!

Compared with his history, material, structural and presumably psychological (*for even inorganic matter "behaves"*), the period of the growth and life of one individual is infinitesimal. What he brings with him out of the past must be overwhelmingly large, and what he can acquire in self change in his individual lifetime must be comparatively negligible. This must, of course, be relatively less true of the higher sublimations, but even here it is doubtful if more than "microscopic" changes can be achieved. Everything indicates that hereditary or innate nature dwarfs all possible acquired characters.

It has been said of poets that they are born and not made. Whether this is or is not true of poets, I am convinced that it is true of mathematicians.

Amongst a sufficiently large class of boys there may or may not be found one, or possibly even two, who are excellent at all mathematical subjects without any effort either on their part or on that of their teacher. But the sad truth remains that the vast majority simply cannot do mathematics at all, with or without personal effort or that of their teacher. They will never be mathematicians.

I wonder whether this is true also of doctors, that they are born and not made. If so, it seems rather a pity that our civilisation should be turning out tens of thousands of practising physicians and surgeons without any enquiry as to whether or not they have a natural inherited aptitude. Perhaps we are trying to make something out of material from which it can never be

made. Of course, we can make registered medical practitioners or officials of a State Medical Service. They can perform necessary legal functions, but only a percentage of them will be capable of giving relief to suffering humanity, and an even smaller percentage will be capable of increasing man's power to deal with humanity's suffering. Perhaps there are two separate functions involved. One, the function of motherly kindness—certainly this belongs more to inherited instinctual qualities than to any response to training. Like the maternal instinct this type of physician is born and never made.

I am inclined to think that the other function is even rarer, though not at all specific to medicine or surgery. It is a quality which can reveal itself in a large variety of forms, but always, whatever form it assumes, it is one and the same quality—common to poets, mathematicians, philosophers, scientists, doctors. Ralph Hodgson had it in mind when he wrote:

“... I stared into the sky,
As wondering men have always done
Since beauty and the stars were one,
Though none so hard as I.”

Looking back forty-odd years, I wonder if, as a boy, it was this spirit that moved me, or just a schizophrenic process characteristic of extreme youth with its accompanying megalomania—a process which may not yet have entirely subsided. Be that as it may, I can remember, when thirteen years of age, sitting on a slope in the Simla Hills with crowds of my school-fellows, all watching an inter-collegiate hockey tournament—all except one, and that one was I. I was watching a large dog that crept in and out between our feet and my thoughts were running in this fashion. “How very like the rest of us this animal is! It has two eyes, the same as ours. How curious also that it has one nose and two nostrils, the same as ours!” I considered its mouth, its tongue and its teeth. I even observed its eyelids and its eyelashes, its four limbs, the same as ours. I went further and noticed that it had apparently four digits at the end of each limb, but if one looked for the fifth, there it was a little higher up! And then I took to thinking that it had hair the same as we had, albeit different in abundance and in distribution. I wondered why this relationship to ourselves appeared to remain unrecognised, for, had it ever been recognised, surely we would have been told in our class!

The next day we broke up. I had been for a continuous spell of nine months in that school, but it required a few hours of the railway journey to my home and holiday for me to learn from two very ordinary men in the carriage the name of Darwin, and to hear for the first time the word "evolution". Their talk was not very intellectual; it was something like this:

"Fancy a man who calls himself a scientist putting out that idea that we are descended from monkeys!"

I knew that we were not descended from monkeys, the monkeys that we ordinarily observed. But in that second I knew a number of the essentials of evolution including the origin of species and the descent of man.

It was many years before I had studied details of the internal anatomy of man and many more years before I had learnt any comparative anatomy or read any of Darwin's works. I did not need the details of the cerebral convolutions, nor the various fossae and tubercles in the scaphoid, nor the microscopic identity of the various layers of the skin's surface and the almost indistinguishable identity, even when magnified five hundred times, of the hair follicles in one animal and another, to tell me that these creatures had infinitely more similarity than difference in their relationship to man. I had seen it all in that dog on the hockey field. I had seen also that my fellow men, or fellow boys, were blind.

Years later, in accordance with the excellent medical curriculum, based as it was in those days upon a new-found materialism, I pursued these detailed studies in medical school and hospital. I learnt what science had to teach about the elements of physics, chemistry and biology. I learnt the constituents of the blood and the chemical functions of the liver, the gastric juices, etc etc. I went on to study morbid anatomy, pathology and histology, the detailed appearance of disease both macroscopically and microscopically. I learnt the chemistry and physics of what humanity suffers from, or is alleged to suffer from.

But it took an excursion out from these places of learning, this time not into a railway train but into the slums of London as a *locum* in an industrial general practice, to teach me what humanity really suffered from. Presumably they suffered, for they came and sat for hours in the waiting-room. But try as I might I could discover none of these chemical and physical,

leave alone pathological, abnormalities which had occupied my five years of studentship. To look for them was like looking for a needle in a haystack. One occasionally found something in a form evident enough to be interesting—and immediately passed it over to the hospital. In fact, one practitioner had a rubber stamp which he was itching to use, but, as he confessed to me, he rarely found an occasion to use more than three or four times in a week of his many hundred patients. It had on it "Hospital Case".

Thus in hospital we were treated to these eccentricities, these extraordinary exceptions to the ordinary sufferings of mankind. These were the patients numbering perhaps one in a hundred who had some recognisable organic disease. What were the other 99 per cent., those who had not or did not yet have anything to interest the hospital? One thing about them was clear; they were the practitioner's livelihood.

One doctor with a busy dispensary had a common prescription for them all. He called it by its initials A.D.T. He did not like my asking him what it meant. He said: "Oh, the dispenser knows." And finally, when pressed: "Well if you must know, it actually stands for 'Any Damned Thing'! She puts in the bottle something pretty harmless that we have got plenty of in stock. A little bicarbonate of soda, some gentian to colour and flavour it, and if they seem a bit nervy she sometimes adds a little bromide. They are mostly like that. You will find out. You have only worked in hospital." And then, apologetically: "You see, I can't be bothered with the damned nonsense. It's a prescription for the general run of patients—those with *nothing the matter with them*."

I said: "This is extraordinarily interesting. Tell me, if they have nothing the matter with them why do they come here?"

He said: "Oh, I suppose they think they have."

"What is it that makes them think they have something the matter with them and that they need to see a doctor?"

He said: "Ask me another. I suppose they are fools."

I thought to myself, because of course I was much too polite to say: "I suppose they are. They must be assuming that you know and can help them."

To cut a long story short, I finally came to the conclusion that I could not go on seeing these people who comprised so large a proportion of general practice, without making some attempt to

know what was the matter with them, or at least understanding why they came to the doctor, and seeing what, if anything, could be done to help them.

Nevertheless, five or fifteen years of strictly scientific education takes a lot of living down. To find out what was the matter with them I naturally put into practice the methods and principles which I had been taught throughout my medical education. In accordance with that education I could not help assuming in the case of every complainer that there *was* something definitely organic and physical the matter with him. The fault lay in me if I could not detect it. The hours I spent during those early years percussing and auscultating chests, palpating abdomens, carefully testing every cranial nerve in turn, assiduously seeking the organic basis for every patient's complaint!

I must confess that on the day that I purchased my first and, as it happened, particularly busy general practice I did reap some success. The retiring doctor had given me a list of ten patients to visit. The first, he explained to me, was a case of Bell's palsy. He said a few words about it. The patient was a little troublesome. She had had a friend with a similar one-sided facial paresis due to a draught and the condition had cleared up within three weeks, whereas *she* was not so fortunate, as her facial paresis had resisted all treatment for nearly six weeks.

He said: "I have gone to some trouble to placate her. I have even got a little galvanic battery to re-educate her facial muscles, and shown them how to use it. Still, they have been very old patients of this practice and you will have no difficulty in annexing them."

I never annexed them.

The seventh nerve was obviously not functioning, but I went through my routine examination of all the cranial nerves. She was deaf on the same side. But the thing about her condition that arrested my attention was that she had a just perceptible paresis of the sixth nerve on the same side, the one that moves the eyeball outwards. That was all. I sat and looked at her and puzzled. Then in my ignorance I thought there might be some embolism, possibly from a cardiac lesion. I asked to examine her heart. This met with instant refusal. Dr. X had been visiting for six weeks and had never examined her heart. It was quite unnecessary.

I did not hear her very clearly as I was still thinking while I

got the stethoscope into position. But very soon I found that I was not listening to her heart, but wondering why this woman of forty-five and the mother of a family was so very modest in guarding the slit of her nightdress with a determined hand on each side of the stethoscope. I put a finger into this slit and while her attention was distracted suddenly moved the garment to expose her left breast. There lay revealed a fair-sized, fungating carcinoma. I made her hold her arm up and examined it. It was fixed to the pectoral muscles. But more than this, it would not move in any direction. It was fixed to the ribs themselves. No need to look further. I folded up my stethoscope and prepared to leave. Everything was transparent. The concealment on the part of the patient, secondary growth in the skull. . . . I remembered the pathological specimens in the museum.

Down in the hall the husband and the patient's mother overtook me, full of agitation.

He said: "Doctor, don't tell me she will have to have an operation. She won't, will she?"

I said: "No."

He heaved a sigh of relief. "I am so glad, she is terrified of operations. That is why she made us promise never to tell a doctor."

I said simply: "It is a pity it has gone too far for operation."

Something told me to avoid using the word "cancer", but I am afraid that my somewhat prolonged investigation and my sudden conclusion and departure had proved too dramatic for all concerned. It seems that in their instinctive or automatic mental operations I, having discovered and revealed the horror, had thereby brought it into being and could never be forgiven. They never wanted to see me again.

Alas for the scientifically trained devotee of medicine and surgery in general practice, such gratifying opportunities of diagnosis will be the exception, the very exception of exceptions, and certainly not the rule in his daily routine! They may merely serve to encourage him along that well-trodden path which he has been assiduously trained to follow throughout his studentship, a pursuit which will gain him much credit from his teachers and learned colleagues, but will leave him without gratitude or appreciation from his patients, and certainly leave him exhausted at the end of each day with little or no discoveries to reward his painstaking endeavours. A certain pro-

portion of his patients will say that he is "very thorough—only he takes so long". They may even attribute his thoroughness to much learning; but sooner or later it will dawn upon him that his thoroughness is due to ignorance.

A wise old teacher of Clinical Medicine once told his assembled class: "You can gauge a physician's length of experience by the ratio between the time he spends listening to the patient and the time he spends physically examining him." Whereas the green student hardly listens to more than the first word and rushes into physical examination—often without reward—the experienced practitioner pays careful attention to everything the patient has to say and frequently arrives at his diagnosis before he looks or tests.

The problem of the busy general practitioner requires ever more experience. It takes infinitely longer to learn to know at a glance or from the first words of the complainer whether or not there is something physically the matter than it does to learn a system of physical examination. I had been naïve enough to take literally the oft-repeated adage of all hospital training: "A thorough physical examination in every case". This is the sort of advice that is given by the clever to the stupid. We compensate for our omissions by putting the onus of care upon our stupid pupils in the same way as we tell our patients to chew every mouthful of their food so that we may more freely gobble ours in a few hurried minutes! However satisfactory it may be in the wards of hospitals to examine every patient thoroughly, all practising physicians know that in general practice it would be not only impracticable but actually beside the point. We don't physically examine our friends when they laugh or cry—or complain!

Of course, if amongst the innocent the complaint assumes some physical *form*, nobody, neither patient nor doctor, will be satisfied without at least some pretence of physical investigation, particularly, as seems always to be the case in general practice, one has not the time to listen to the complainings behind the complaint. But to nurse the ambition of diagnosing the nature of ninety-nine out of a hundred of these complainants by dint of increasing care and thoroughness of examination is to bark up the wrong tree. If the newly qualified enthusiast starts this way, well fortified with his excellent orthodox training along physical lines, he will long resist the heresy I am here teaching,

and persist along the path which will waste his time in an almost barren wilderness.

He will eventually learn, and I must confess that I was particularly slow in this branch of my education, that he is wasting his time. All these dozens of chests, abdomens and stomachs really have, as the old practitioner originally said to me, nothing whatever the matter with them. Why then do their possessors send for the doctor? Why then do they complain of this or that ache or pain?

After two years of daily examinations I could resist the truth no longer. The pain originates in their minds, not in their stomachs or chests. This conclusion was reached by me most reluctantly. I had spared myself no effort to master the intricacies of the physics, chemistry and biochemistry of the body. I had been promised by my teachers that in so doing I would understand the ills of humanity and be able not only to comprehend, but to cure these ills in so far as medical science, supposed to be a very advanced science, was able. I might even if I were a very good student extend this power of man over nature and advance the science of medicine for the benefit of all. Was the kingdom of knowledge that I had for years so enthusiastically built up proving itself bankrupt? Was I to admit my bankruptcy and start afresh? Must I admit that the books I had read all these years were the wrong books? Should I burn them and begin again, in the wilderness of ignorance, to find a meaning for this phenomenon that confronted me—not once a day but ninety-nine times a day, ninety-nine times out of a hundred? I decided that no other course would be relevant to my observations, that no other course would satisfy me.

It was on this account that I sold my general practice and embarked upon a training in medical psychology. It was hard to think that the riddle of the universe in so far as it included the mystery of human illness had to be approached from some other direction than that of physics and chemistry. The prospect of reaching an easy material or mechanistic solution receded to an infinite distance. Why could not everything be as simple as the chemical experiments in the laboratory? Why could it not be? But my two years' experience as a general practitioner had convinced me that so far as my observation went it certainly was not. Where could one learn the meaning of all these complaints that had no discoverable organic basis? Could the study of

psychology provide an answer? I doubted it; but where else was one to look?

I did not appreciate at that time that the function of the mind itself was merely a product of the function of the physical and chemical universe, albeit so very much advanced a product that its relationship to its lowly origin could hardly be traced as a continuous process. In the meantime, here were masses of suffering people demanding relief and coming to me on the erroneous assumption that I understood their troubles, knew the source and origin of their pains and could get to the root of things and make them whole. I recognised that I was in an utterly false position. It was no excuse that they insisted upon putting everyone classed as "doctor" in this false position, or that many other doctors were sublimely content to sit on the throne and wear the crown bestowed by popular ignorance, ignorance not only of anatomy and physiology, but particularly ignorance of the doctor's ignorance of all else. Where the blind lead the blind there will be doctors, priests, lawyers and politicians.

All the self-satisfaction which had been accumulated as a result of these very sound basic studies, physics, chemistry, biology, pathology, biochemistry, and even anatomy and physiology, was leaving me at the impact of the reality of the patients in general practice. If these solid and complete gods were false, where indeed could one find a more tangible or reliable deity? This was clearly no good. I must try. However faint the hope, it was better than the maintenance of an utterly false position. After a few tentative attendances at University courses of lectures in psychology I finally settled down to a rather strenuous curriculum of study in medical psychology at Bethlem Royal Hospital.

At the outset I was considerably heartened. My old gods had not to be scrapped after all. The lectures were very much of the old familiar variety. For instance we had the same old histology—with the only difference that this time it had a special predilection for nerve cells. We had the same biochemistry, chemistry and physics. Nevertheless my thought was: "This is merely the beginning of the course, a very sound beginning indeed. Eventually, by the end of the course, we will get there."

We never got there. We never got anywhere that mattered for practical purposes. At the end of my training in psychological medicine, just as at the beginning, I sat in a side room with a

mute patient who made signs and diagrams in the air, and all my histological and neurological studies left me just as puzzled as to the meaning or source of her aerial hieroglyphics. Not one delusion or phantasy could I even begin to understand. The fact that nobody else around me seemed to understand these things, and that examiners did not require an understanding of them and were not interested, was no consolation. I knew that I had failed. Despite diplomas and degrees I knew that I was utterly ignorant. I knew that I was in no position to help anybody—unless it were through the strength of their delusion that I was.

I remembered in the early days, after spending a whole afternoon with a particular patient and making careful notes of her remarks and her gesticulations, I arrived in the medical officers' tea-room to find the most erudite amongst them, the senior resident, in expansive mood. I seized upon him. I thought: "Now I can get someone to tell me what the meaning of all these mysterious phenomena really is!" I placed the case before him with the question: "Can you understand all that?"

Presently the look of perplexity lifted from his face; light dawned in his eyes. He said: "Ah! you are talking about Mary Jones." He said: "Why, she's just a little bit balmy." And that was all I got. My insistence that this balminess was the very symptom I had come there to study only elicited from him the patronising remark: "When you are a bit older you will give up all that nonsense and realise that we are here just to earn our bread and butter, with a bit of jam on it too if we can manage that."

It did not take me so long at the mental hospital as it had taken me in general practice to discover that medicine had nothing to teach, nothing that was relevant to the psychological phenomena that filled not only the asylums, but also the practitioners' waiting-rooms, and indeed the wide world itself. Surely there must have been people like me. Surely people must have lived before who had applied their minds to these outstanding and, as I was now beginning to think, most fundamental of all problems. Where were they? Was there no school which they had inaugurated? Could I not learn something? If the answer was positive I must find this school and pursue the course of study which it would prescribe.

Throughout my education in medical psychology I had at every turn encountered derisive references to the theories of

psycho-analysis. In fact, it interested me that no psychological discussion or even reference was complete without the introduction of a psycho-analytical jibe. Indeed, psycho-analytical theory in the hands of the psychiatrists in a psychiatric study circle was at that time comparable to the function of the light comedian in an otherwise dull and boring drama. Nevertheless, like him, it was the soul of the party. I had made good practical use of this attitude towards the subject in the course of my medical examinations in psychiatry. Examiners and I had laughed together and got on very well. But having finished with that, I turned to what had really impressed me throughout the course, namely, that as these people could offer not even the beginning of an explanation of psychological phenomena, perhaps the contribution which they so joyfully ridiculed was the very one in which the secret lay. Perhaps it would prove to be the stone which the builders had rejected. . . .

I therefore left the dull stage with the express object of fraternising with this discredited comedian.

The President of the Psycho-analytical Association was not appreciative of the mood in which I approached him. Maybe that was because I unwittingly reflected something of the mental hospital atmosphere of that time, in which psycho-analysis was assumed to be a not-to-be-taken-too-seriously and rather dirty joke. Nor did he take kindly to my remark that I had no wish to be psycho-analysed, but merely desired to be introduced to a course of study and the appropriate prescribed reading. Nevertheless, I did partly understand his insistence that there was only one book for me to read at this stage, and that was my own unconscious mind. What a curious thing! In all my studies I had never consciously thought of turning my attention inwards.

Here I am tempted to make a little psychological digression. Perhaps all knowledge, all seeking of knowledge everywhere, is nothing more or less than a mode of defence against analytical *insight into oneself*. It is as though we felt we must absorb an intellectual activity, or a curiosity-impulse which arises in us, as quickly as possible in a study of our *environment* rather than of ourselves, lest we should place ourselves in the dangerous rôle of introspection and be forced to discover these very things about ourselves (our passions) which we have been so assiduously at pains to keep from consciousness.

And now this man was telling me that not only had I studied

the wrong books, but that what I wanted could not be found in any books anywhere, neither could he or his colleagues directly teach it to me. Perhaps, after all, this was the great discovery I was looking for and missing throughout my life, namely, that the seeking of knowledge, such as had been my endeavour, was nothing more or less than a *flight from knowledge*. Anyhow, it did seem that step after step in my search had merely taught me the bankruptcy of these endeavours. At last I had come to an educator who said that not only were the books wrong, but that they were the wrong *method* of approach, that all books, all ordinarily accepted methods of learning, were wrong. And after all, might not this be the lesson that my own personal experience should have taught me? This would explain, perhaps this was the only thing that could explain, why after thirty years of striving I still knew that I was totally ignorant.

It took me a few weeks to think over the position. I shall not go into the unconscious motivations that led to my choice of an analyst . . . all the escapism into which I had at that time not the slightest insight. But I can tell the reader this much, that after a few years of analysis my hitherto repeated excursions along the various diverse lanes of knowledge ceased. Something had been brought to rest. If you ask me why, my immediate answer would be that now at last I felt I knew. If you asked me what I knew, I might not give you the true answer, but I would be inclined to say I knew that the human mind was not competent to solve this riddle anyhow. I knew that it, the mind, was concerned with many things, but that these things were not "the truth". Though perhaps that answer has no appreciable bearing upon the truth, I would add, if you like, that the mind was bound up in an asylum of inescapable madness. I had found that the mind was a cage in which warring passions fought with one another; that the perceptual level of consciousness was a thin film upon the surface of volcanic forces, a film which had no ability of objectively appreciating its environment, but which was concerned chiefly, not with knowledge, but with obscurantism, with preventing the intolerable volcano from disturbing its own illusionary serenity. The fact that it never wholly succeeded in keeping these deeper forces from emerging upon the surface did not seem to it so important, for it was pre-occupied with the ostrich policy and could succeed in maintaining an illusion of sanity only in so far as it succeeded in avoiding

or evading insight into these. As I have said, to parody or pervert Herbert Spencer's famous formula of Evolution: Mental Evolution is a repression of the mind with a dissipation of its residual energy in a centrifugal or environmental direction, with the object of avoiding insight into its own turbulent interior!

So the voyage of discovery, perhaps better described as an Odyssey since its direction was all unsuspected, eventually led back from projection of interest on to the outside world, back to introversion and relative tranquillity. Whether this should be regarded as evolution, development and progress or as regression to a primitive state of dissolution and morbidity is a matter of opinion. There is something to be said for either point of view.

One thing I do know: that I have at last learned something, something which I would like all other knowledge-seeking persons to learn.

Though at one time, like us all, I imagined myself normal and satisfactory—apart from what I felt to be my highly creditable thirst for knowledge and understanding of the universe—in retrospect, as a result of the analysis which inadvertently fell my way, I can now recognise that I was in a more severe category of mental disability then (before the analysis) than that which I now enjoy . . . and I may say “enjoy” is the appropriate word. Though it may be philosophically questionable whether this euphoria is due to a greater or a lesser degree of sanity, I cannot avoid having my views.

Therefore I want to proselytise my fellow madmen—not those beyond recall, not those requiring leucotomy, short of decerebration or decapitation—into a similar enlightenment and enjoyment—providing experience and *rehabilitation*; and humanity as a whole into the creation of a happier (*i.e.* saner) world.

Unlike some of our industrious psychiatrists, I cannot find myself as enthusiastic as I should be about such domestic tasks as moving a “mad” patient from one category of disability to a lesser one, but rather in the attainment of a superlative freedom from madness of intelligent mankind as a whole. Though it be much to my discredit, I confess that I have not been able to summon very much enthusiasm for bringing the confirmed dement to the improved stage of “doing a little digging in the garden”. It is especially for the learned doctors that I am writing this *Odyssey* of my wanderings in their domain and in the

domain of the lesser children, their patients, who lean on them. I want the intelligent people to become even more intelligent, I want to teach them the intricacies of the journey that I have pursued, however inadvertently, so that they may proceed where I have ceased and grow into an understanding of the mind and an ability to help themselves and others, even before that great but very distant day when future learning may, I hope, link materialistic research with the most complicated product of material evolution, the mind, and deliver into our power an exact knowledge and method of controlling these incipient dementias, both biological and sociological, till we are definitely embarked upon the voyage to our modern Ithaca, or Utopia.

CHAPTER II

AETIOLOGY

PART I: AETIOLOGY OF NERVOUS ILLNESS

APART from those rare cases, the delight of every non-psychological clinician, where mental symptoms are the direct result of physical or chemical damage to the brain substance, the aetiology of nervous or psychogenic illness presents us with one of the most absorbing and seemingly overwhelming problems that science has to offer. We can better understand the failure to find a solution to this problem when we realise the extraordinary revolution in all knowledge which would follow its success. I am convinced that it is far from the simple matter of cause and effect of environment upon the individual as such; and that is why investigations based upon this premise have been, and presumably always will be, doomed to failure.

To approach this problem with any hope of even the beginnings of a solution it is first necessary to divest our minds of the idea of an individual being born "normal" and then proceeding to be made neurotic or psychotic by circumstances which befall him in his single lifetime. The professional psychologist has surprised the amateur—and all intelligent persons belong at least to the latter category—by pointing to causes in the earliest childhood, infancy or even babyhood of the patient, but I think the psychiatrist has indicated even deeper roots than these when he classifies all the non-organic, or not-chemically-induced, mental illnesses under the general term "biogenic psychoses", indicating that their aetiology is biological.

To approach this question we should, I think, first divest our minds of the illusion that an individual begins with birth or conception and ends with death. Rather we should recognise that the life process continues through the species and that each individual is merely as it were the temporary fruit, sign or symptom of that process. We will then see that the problem of his ills is as deep as the problem of mutations and of the evolutionary process itself. So we may see that we are, from the very start of our investigation into aetiology, confronted with problems which biology itself, even in its more apparent and

therefore presumably simpler sphere, has not yet solved. The matter would be far more simple if we could rely upon the original Lamarckian¹ hypothesis of the inheritance of acquired characters, for then we would merely have to trace the morbid process, the failure of adaptation to environment, through the generations to arrive at our pathological end-products. Unfortunately for this simplification the modern biologists have shown the Lamarckian that all is not so simple. Their greatest triumph has been that, whilst seeming to destroy this understandable and perhaps manipulable process, they have been unable to offer any comparable explanation in its place. However much they stress natural selection, however skilfully they juggle with a complexity of genes, the mechanism and origin of their mutations, particularly the successful and adaptive ones, the ones that matter to us, remain shrouded in the darkest mystery. If the aetiology of these is so utterly obscure, what wonder that the aetiology of unsuccessful "mutations" including idiocies, imbecilities, epilepsies, schizophrenias, paranoias, affective disorders and of course the psychoneuroses, is similarly without explanation. This is a brief glimpse of the gloom which must inevitably shroud the would-be aetiologist. I am fortunate in not sharing it.

While agreeing with the biologist that it would seem that the original concept of Lamarckism would have to be modified in the light of biological discovery and opinion, I am quite sure in my own mind that the biosphere as a *whole* reveals that some form of Lamarckism (interaction between evolution and environment) is inescapable and that the onus lies on modern biology, or that of the future, to provide the detailed evidence, the mechanisms, to account for this self-evident ultimate truth. It is a pity that I cannot say more about this highly technical and controversial matter in this work as it deserves a book to itself.

Psychiatric case-taking alone is constantly bringing home to

¹ The first general theory of evolution was proposed by Jean-Baptiste de Lamarck. His theory was outlined in 1801 and set forth fully in his *Philosophie zoologique*. Lamarck recognised a fundamental continuity underlying the diverse kinds of animals and believed that there had been a progressive development of forms. His theory in his own words was: "The environment affects the shape and organisation of animals: frequent continuous use develops and enlarges any organ, while by permanent disuse it weakens until it finally disappears: all acquisitions or losses wrought through influence of the environment and hence through use and disuse are preserved by reproduction".

the clinician, particularly if he takes a careful family history going back for more than one or two generations, that the springs of even neurotic illness, leave alone psychotic, go back to a surprisingly early period, and that the forms in which they manifest themselves are subject to innumerable variations. When statistics show us that amongst gifted children with an intelligence quotient of 130 or better, 53 per cent. had fathers of the professional class, 37 per cent. clerical workers and 10 per cent. skilled artisans,¹ and when we bear in mind that the professional class constituting only 2 per cent. of the population produces 50 per cent. of the children of high natural endowment in spite of their relative meagreness of propagation, we may well ask whether it is a mutation proceeding through the generations or a passing-on of acquired intellectual capacity, even if no certain answer is forthcoming. The general impression here, as in the statistics of the inheritance of psychogenic disorders, is that their basis is biogenic or phylogenetic rather than ontogenetic. This realisation will bring us to seek the amelioration of mental health in a eugenistic or sociological programme rather than in psychotherapy—no very new concept, but nevertheless one deserving of the most serious political consideration. Let us remember that after a lifetime spent in the study of this subject, Havelock Ellis concluded that the eugenistic method was the only hope for the improvement of mankind.

In the absence of such a fundamental method of tackling the practical problem of illness, the psychotherapist is in the position of a builder called in to shore up the rickety walls of buildings with crumbling foundations in which even exact knowledge of Mendelian inheritance will be of no practical value. He has perforce to confine his attention to individual methods within the individual lifetime of the developing or developed mind of the patient who consults him. His knowledge of that patient's family and ancestral history is useful only to help him form an assessment regarding the prospects or futility of attempts at amelioration.

Nevertheless, as some of these minor psychogenic ills are relatively superficial though far-reaching in effects, their aetiology, apart from hereditary predisposition, may well lie to a sensible degree within the individual lifetime of the patient. Indeed, we all know that some emotional disturbances can have

¹ Terman, as quoted in Henderson and Gillespie, *A Textbook of Psychiatry*, p. 48.

their immediate precipitating and even most important aetiological source in events of the very same day or hour. Perhaps these most recent causes and effects will be as speedily dissipated. But this renders the successful dealing with them more, rather than less, important.

Similarly, extending our aetiological investigation backwards through the past days, months, years, down to infantile traumata, now repressed from consciousness though still active within the psyche, may also have this practical value even if their emergence to a conscious level and therefore their accessibility for treatment becomes progressively more difficult, but not impossible, to achieve. Thus we find that while psychogenic disorders, like all others, may have their basis in biogenesis, there may be increasingly recent and superficial precipitating causes without which the symptomatic disturbance may never have emerged. These latter we can deal with by a process of psychotherapy, superficial psychotherapy if they are so recent as to be conscious or preconscious, deeper analytical psychotherapy if they have been forgotten or repressed, particularly if they belong to the period of the amnesia of infancy.

In practice it is found that apart from such traumatic happenings as those incidental to war or accidents, recent and conscious sources of disturbances are usually dealt with by a person either by himself or with the co-operation of friends and advisers. It is only when symptoms emerge, the source and aetiology of which is inaccessible to the patient's own consciousness, that he or his doctor finds him suffering from an incomprehensible malady and considers that he requires the assistance of a psychologist.

In short, most cases that consult the medical psychologist, apart from psychotics, are suffering from symptoms psychological, or more often physical, the cause or aetiology of which is entirely unknown to them because it lies within their unconscious mind. Analysis invariably reveals that, whatever source or precipitating causes increasing in depth may be revealed, the nuclear cause is traceable in most cases to the earliest development of that individual's emotional and conceptual life, specifically in cases of hysteria to his emotional relationships to his parents, their surrogates, siblings and others during his forgotten infancy; similarly to a lesser extent in Anxiety States; and in Obsessional Neuroses to an even earlier date in the formation and development of his emotional patterns,

even before they included, as part of their essential character, relationships to persons in his environment.

This very limited aetiological scope is the province of analysis and psychotherapy, and within it a limited, but in some cases very useful, amelioration of the patient's symptoms and a subsequent helpful adjustment to environment may be achieved.

PART II: FURTHER AETIOLOGICAL CONSIDERATIONS

The following contribution to aetiology may appear rather incomprehensible to the reader who is not versed in psycho-analytical conceptions, but no account of aetiology would be comprehensive without reference to it. There is hardly space to elaborate it at this stage, but it will be explained more fully in the more appropriate section dealing with treatment at the conclusion of the clinical material.

Whilst it is manifestly impossible for any form of psychotherapy to remedy hereditary predisposition, the earliest points in a pathogenic process, it is perfectly clear that precipitating factors, the most recent links in the chain of pathogenic events, are daily dealt with by emotionally disturbed persons even in their ordinary relationships to friends quite apart from special psychotherapeutic measures. The young woman who has become hysterical through a disappointment in love may be ameliorated by a successful love affair, or even by the sympathetic understanding of a benevolent parent-figure.

Thus, starting at the proximal end of a series of emotionally traumatic causes of psychoneurotic illness, analytical psychotherapy may trace in ever-deepening succession at least the *individually acquired* causes of the production of internal stress and external symptoms. Superficialities may not be far to seek, and superficial but often striking amelioration may speedily ensue. Unfortunately, apart from traumatically precipitated war neuroses, and often even in these cases, the effective aetiological factors in the vast majority of psychoneuroses are operatively important in ratio to their developmental depth, and hence in the difficulties experienced in unrepressing them and bringing them fully into conscious memory where alone they are accessible to modification in the light of reason and ego control. In the course of analytical treatment the analyst finds himself receding ever further back developmentally towards that period in the

patient's life when his emotional patterns were being formed and constantly modified, often morbidly, by the frustrations and opportunisms, external and intra-psychic, and ensuing conflicts which their natural development encountered.

In the course of this process it is invariably discovered that, apart from hereditary predisposition, the essential pathogenic factors relate to the earliest emotional development that took place in the patient's infancy or in his transition from infancy to childhood.

Id: Theory of the Libido: It is in the light of these discoveries that the psychogenic aetiology of neuroses, or the nucleus thereof, is said by psycho-analysts to lie in the Oedipus or pre-Oedipus level of development. A scheme of what is called libidinal organisation has been postulated by Freud and elaborated by many of his followers, conspicuously by Abraham, Ferenczi and others, which begins with the auto-erotism of earliest babyhood with its oral erotogenic level, and basing itself upon the sensations derived from physiological processes, proceeds with increasing complications to what is called genital libidinal organisation with its emotional relationships to "whole-object" or personalities (principally mother and father or their surrogates) in the infant's immediate environment.

It must be said of this aetiological scheme or theory that one's experiences in the deeper analysis, not only of psychoneurotics but also of all character types, increasingly brings home to the analyst with his ripening insight that his patients differ essentially or fundamentally from one another in the relative degree and intensity of the various types of levels of their libidinal organisation.

The impression is general that every one of them has failed in varying degrees to reach a fully mature genital-object-love level of libidinal organisation. Every one of them has left a varying percentage of libidinal energy fixated at more primitive stages on the road from oral autoerotic libidinal beginnings through anal, urethral, phallic, towards genital object-love. We see the man, however legal his marriage and large his family, incapable of true mature love of any person, indulging his phallic part-object or fetishistic urges on a possessor of beautiful legs or hair, and at the same time insisting upon an anal-possessiveness (exclusive possessiveness) of an unloved (unloved in a mature sense) wife, and frequently treating her to sadistic

mental and physical cruelties. Such mental attitudes and behaviour on his part may be as compulsive as those of the obsessional's symptoms and as difficult to cure; for, like the latter, they will need a very deep analysis, capable of recalling to memory at least the frustrations of his (unconscious) attempts at genital object-love at the Oedipus stage of his life, and the consequent regression of his libido at that early age (three to five years or earlier) to its more primitive fixation points, anal-sadistic and oral.

The Super-ego: An intra-psychic force similarly early in origin and of almost comparable depth, a force which enters into conflict with libidinal aims and indeed whose function seems essentially that of mentor, censor and prohibitor, is called by psycho-analysts the "super-ego". It appears to have its origin at a surprisingly early stage of life, even before one year of age. It is as though very soon after the baby, at the second (biting) oral erotic stage of cannibalistic phantasy at which it expresses its love by eating (in phantasy) the loved objects, proceeds to fear being eaten by them. The primary pleasure phantasy of eating will come into conflict with this fear of being eaten and will thereupon tend to be restrained or modified by the consequent phantasy of talion punishment. The super-ego has arrived. It is mentioned because in psycho-analysis it is more readily amenable to modification than are the more fundamental organisations of the libido.

The Ego: The ego, or so-called reality sense, is relatively later in development, and its function is, from the start and throughout life, more or less vitiated by the influence of these already established and relatively primitive warring elements. Their influence emanating from the unconscious in which they essentially reside is largely inaccessible to the ego or reason and unaltered by experience however contrary or disastrous. Only in so far as analytical therapy can facilitate their emergence into consciousness is it possible to effect diminution of their influence and to release intra-psychic energy, absorbed in their activities, for utilisation by the ego with a consequent amelioration of symptoms and of ego vitiations emanating from them.

This brief excerpt from deeper analytical psychotherapy is given to illustrate the basis of the analyst's impression that the aetiology of neuroses and character traits, at least the most

fundamental aetiology amenable to our treatment, lies very far back in the individual's life.

There are other theoretical psychopathological constructions which are mostly modifications or simplifications of this psycho-analytical concept and which, like it, claim to be based on clinical and analytical experience. They include for instance the racial unconscious conceptions of Jung and the wish-for-power principle and organ inferiority of Adler. But I shall not go any more deeply into the matter in this preliminary section on aetiology. Even the *beliefs* of man, including those which claim to have their source or justification in observation, are not free from the influence of unconscious forces, including resistances, the effects of which he has not been able to assess or to discount. Judgment can never be guaranteed completely free from bias.

It has been said with some justification that every unanalysed person can be guaranteed to treat a mentally ill patient incorrectly. I would extend this sweeping assertion and say that every adult can be guaranteed to treat a baby, infant or child incorrectly, and probably the more incorrectly the more they have made a serious study, on an ego plane, of the subject. This last type of treatment is analogous to the love-making of the person who has "read it up in a book". The only qualification for appropriate treatment of patient or child is to have studied by *personal analysis* the mental patterns and child-structure within one's own unconscious mind.

From an aetiological point of view I may say that clinical analytical experience has led me to the opinion that however true may be the above-mentioned concepts of psychic structure, psychopathological changes and their development are not so much a direct result of exceptional environmental influences even in the earliest years (such for instance as cruel treatment from a parent—though admittedly all traumata leave their mark) as they are of the reaction of *that particular psyche* to passive and frustrating influences of even the most commonplace and ordinary environment. This reaction depends more on the hereditary predisposition of the particular psyche than it does on any exceptional environmental variation. In other words, how the mind reacts is largely determined by heredity, and only to a lesser degree is environmental experience responsible for changes in its pattern tendencies. In this respect, too, the

individual's life is almost negligibly short in comparison to his racial heritage.

My conclusions regarding aetiology are thus comparable to those of the modern biologist regarding evolution, namely that changes and modifications are produced from within on a genetic basis, in the form perhaps of mutations, rather than as a result of so-called acquired characters. In fact the characters acquired are predetermined more by the inherited nature than by the particular environment encountered. It is not so much what we experience but how we react to it that matters—and this last is genetically determined.

Nevertheless, I would here also as in the preceding Part insist that evolution or change must proceed from the cumulative and progressive effects of interaction between subject and object—between the living organism and its environment, between the psyche and psychic environment and experience—if only from the fact that strictly scientifically it is as impossible to draw a line between where psyche ends and environment begins. Man is constantly ingesting and projecting his so-called environment, and incorporating it within the substance of his organism. Even the individual cell is full of extraneous matter which it is in process of oxydising, incorporating or excreting. It must be truer to regard the extraneous cosmosphere as part of the biosphere and inseparable from it, and the two together with the sociosphere as inseparable from mind.

If we see that the aetiology of psychogenic illness, like that of psychogenic health, is an integral part of the cosmological problem, our failure to solve its riddle or to effect more than superficial influences upon its course becomes readily understandable.

CHAPTER III

CASE-TAKING

AFTER our brief, preliminary considerations or theorisings it is time we struck a more practical note, for this book purports to be essentially clinical. Its object is to present the reader with the actual data of clinical observation.

To obtain these data it may be helpful to have in mind certain general principles and a certain scheme of case-taking, however fluid and extemporaneous. More important than any scheme of case-taking is the general principle of infinite and unvarying *tact*. It is more important than all other considerations put together, for without its *consistent* application no progress will be possible. It is the essence of case-taking, particularly in psycho-neurotic practice. True tact is very different from pretence. Many patients have a special facility for seeing through the latter, thereby rendering all treatment hopeless from the start. To be genuinely tactful requires a true understanding, a lively consciousness of the repressions and defences of the patient, whilst at the same time being oneself free from personal repressions and defences.

First and foremost the psychologist must be an observer and a listener.

Do not thrust your own behaviour or words upon the patient. Only be content to look at *his* spontaneous behaviour, his visual expression—if possible before and after he sees you—his initial behaviour, the manner in which he walks from the waiting-room to the consulting-room and so on.

If he initiates the conversation, do not interrupt him. But do have a pad or exercise-book and pencil ready to take down what he says as he says it, for this is a most valuable contribution to the case material and one which you will not be able to re-invoke if you miss this special opportunity. The vague description of psychoneurotic experiences is often, like dreams, difficult to recall if you have not noted it at the time.

Of course you may have a scheme in mind, but do not thrust it upon the patient until the opportunity is ripe, or in obtaining

complete answers to your questions you may miss everything that matters.

The elaborate, exhaustive and exhausting schemes of psychiatric case-taking familiarly met with in the standard textbooks have little place in this would-be alive and practical work. On the other hand, as this introduction is essentially clinical it may be considered necessary to include at least some outline of a clinical approach. I will, however, make no attempt to be compendious. A compendious chapter on such a subject is of more theoretical than practical value if only from the fact that an initial psychiatric examination unfortunately has a time limit, not to speak of the limitations of patient's and examiner's endurance.

I shall confine myself to the barest outline, allowing the student to fill in details in the light of ripening experience and with reference to particular cases. As I have said, to begin with we observe and listen if the patient is volunteering information, but sooner or later we will want to take his name and address and other particulars, and if he sits mute awaiting our lead, I consider it quite good psychiatry to start with these questions. Questions on matters of fact will help to put him at his ease and his manner of answering will in some cases not be negligible in value. Of course, in psychotics these necessary questions may be supplemented with a few others to establish his orientation in space and subsequently in time, but this is hardly relevant in dealing with psychoneurotics. We will then wish to note the patient's age, his state, single, married, etc., size and particulars of family, occupation present and past. If he has hitherto volunteered nothing we may now ask him to outline his symptoms or complaint.

At the first interview we wish to obtain a brief outline of the main features of the patient's *symptoms* and so far as possible of their *duration*, development and *aetiology*. With a view to learning something of their genetics, or the patient's hereditary pre-disposition, we ask for details of his *family history*, his father and mother and their relatives, his brothers, sisters and siblings. We then proceed to his *past history*, the nature of his birth, suckling and babyhood, infancy, childhood, school experiences, medical and surgical history, sexual development including childhood traumata, puberty, masturbatory practices, sexual struggles, early homosexual and heterosexual tendencies and activities,

love affairs, courtship, marriage, contraceptive practices, business, recreational and religious preoccupations. Through this chronological sequence of events we now resume his *present-day* story, business and social preoccupations, if not already obtained, his current sexual life, current physical disabilities and alcoholic indulgences, relaxation, sleep, dreams, and if possible the relationship of symptoms and their onset to all of the foregoing. It is usual to conclude with a physical examination with particular attention to the examination of the central nervous system. Even after this, if only for practical purposes, it may be advisable to gain some knowledge not only of his financial worries but of his economic position.

I usually proceed more or less in this order, jumping in due course from a mere tabulation of symptoms and their duration, to the less emotional matters of family history, infantile neuroses, previous nervous breakdowns (including those in relatives), and from there moving to his current life and current problems. It is essential that the movement should pay due regard to the patient's psychology and that we should not, for instance, suddenly confront a sex-repressed patient with direct questions bearing upon sexual matters. But even in regard to sexual matters there is always a tactful way of approaching the subject. For example, we could ask a young person the age when puberty arose, or the menses began, and note his or her reaction to such a question before trying further. It is better to forgo information at a first interview than to arouse the defences and resistances of the patient. However ambitious our programme, there must be no sacrifice of tact or of due consideration of the patient's limits and resistances in this pursuit. It is better to forgo, or rather to defer, a complete outline than to sacrifice *transference* for the technical purpose of completing our preliminary investigation at the first interview. An adequate reservation of time for this interview is essential. Hurry is the antithesis of psychological consideration and assessment. The physician must for a time lean back, listen, observe and think unhurriedly, otherwise he will miss all but the most obvious and superficial manifestations, and may indeed find himself at the end of the interview unconvinced of the diagnosis which, with a little calm thought, would probably have been borne home to him.

Unless it is imperative that a diagnosis should be made at the

first interview, it often makes for greater security against error if the psychologist should make no attempt to force one upon the case, but should be satisfied to observe and listen until the diagnosis is borne home to him, is as it were forced upon his passive receptive mind. If this is not forthcoming at the interview, it is a particularly good plan, if practicable, to suggest a few analytical sessions, as one is justified in having every hope that these, especially if they include one or two dream analyses, will reveal or confirm sufficient of the psychopathology to establish a diagnosis beyond all doubt and possibly even to permit some assessment of the prospects of amelioration. Instead of sticking a label on a case it is best to wait for a label to be thrust into one's hand by the case itself. Only then can the label be guaranteed to be correct.

I am reminded of an incident at one of my academic clinical examinations when, filled with the anxiety and hurry usual on such occasions, I spent a hectic ten minutes questioning an irritatingly slow and unhelpful hospital patient without achieving anything except the information that he had suffered from an attack of influenza some months previously. It was my own anxiety that blinded me to the obvious diagnostic observation. Only after I had sat over my clinical paper for some time puzzling about this case and had, in fact, given up all hope of diagnosing it and consequently relaxed, that something about the facial appearance of my slow-witted friend dawned upon me. I went back to his cubicle, opened the door and gazed at him from a distance... to observe what I had previously missed, namely, the typical facies of post-encephalitic Parkinsonianism.

Although it is as well to have in mind some systematic outline of a scheme of case-taking and examination, as often as not investigation has to pursue an extemporaneous course. As often as not the best schemes have to go by the board. The mind of the examiner must be sufficiently adaptable to permit of this sacrifice. I could probably think of many typical and striking examples to show how every preconceived scheme has to give place to the needs of a particular case. Instead I will give an abbreviated account of a patient I have just seen, this afternoon.

The patient was a young Dutch naval officer who had come through the recommendation of his British fiancée. Thus he arrived without any doctor's letter. He seemed unnecessarily stiff, serious and silent. When seated I asked first his name,

address present and permanent, telephone number, the name of his recommendation, his age, single, married, length of service, etc., writing them all down. Then I asked his purpose in coming to see me. He repeated the words he had used on the telephone in reply to the same question:

"I want to know if my nerves are right or not right."

I said: "Well, tell me what you complain of, what troubles you."

He said, with the first suspicion of a smile: "That is just it, I complain of nothing."

"Well, why do you come to me?"

He said: "It is a long story, but to cut it short: I was at the barracks, where I am in charge, and a car came to take me to a medical examination. There I was entertained for an hour over coffee with a medical major in the Dutch army. He then left me. After a time I got restless and went downstairs and found myself in a room with this same major and two naval surgeons. They said my nerves were bad and I was invited to enter a hospital which they named. When I told them I was engaged to be married they sent me out of the room for a few minutes, then called me back and said that instead of going into the hospital I could get married at once and take six months' leave. I told them I wanted neither the hospital nor the leave, but they insisted that it should be one or the other. So I came to London and told my fiancée and she sent me to you."

I asked him: "What is the matter with your nerves?"

He said: "Nothing, so far as I know. That is why I have come to you to find out."

I tried again: "What did the major talk to you about for an hour?"

"He didn't talk, he seemed to be looking at some papers half the time. In the end I talked to fill up the time. I showed him some photographs I had, though I couldn't be very familiar with him as he is of senior rank."

"Can you tell me the gist of the conversation?"

He could not. "It was about nothing in particular."

This problem, by the very absence of all clues, was becoming more intriguing. When nearly an hour had passed with the mystery still unsolved, it threatened to become less intriguing than exasperating. No scheme of case-taking offered any possibility of help. At last I said to him:

"Have you any papers—your medical-board papers or official letter or anything you can show me?"

He was rather reluctant but eventually he produced one. It was a long letter telling him if he got married he could be on leave for six months, otherwise he must go into the hospital. One phrase caught my eye. It was "ideas of reference". I pointed to it and asked what it meant.

He said his fiancée had told him that he must not be content to enjoy six months' leave with this label, "ideas of reference", pinned to him or he might find promotion barred when he resumed his normal career. At last we had it. That was why he had come to me, to verify that his "nerves" were all right. Light was beginning to dawn. I tried a shot.

"Have you ever gone to any doctor before this to verify that your nerves were all right?"

At first he said "No." Then he said: "I did go to a doctor two months ago to ask for a certificate that my *physical* health was all right."

"What did you think might be wrong?"

"I knew nothing was wrong, but other people were implying that I had something wrong."

"What? Tell me about it."

"Well, it was while I was on leave in Liverpool. A bus conductress or two got hold of my arm to feel how thin it was, and then men in the street, civilians as well as soldiers, men that I didn't know, made suggestive gestures in my direction. They put a hand in their overcoat or trouser pocket and shook it."

"With reference to you?"

"Yes."

"What did it mean?"

"They made the sort of movement of self-abuse. I could not remain in Liverpool where it kept occurring, so I left and came to London, but I noticed it there also once or twice."

"Did you do anything about it?"

"Yes. I went and complained to the doctor and asked for the certificate to say I was all right as I have told you."

"What doctor did you go to?"

"To the major, the same one that had the coffee and talk with me a week ago."

So at last the story was complete! It had taken nearly an hour

and a half to extract. The rest of the case history occupied only a few minutes.

"Are your father and mother alive? Did they or any of their relatives ever have a nervous or mental breakdown?" Brothers and sisters, his position in the family, the state of health of the others. Had he himself ever suffered from his nerves or other illness. His recent history of stresses and strain preceding the "events" in Liverpool, any other similar events past or present. The answers were practically all negative and not very helpful to diagnosis or treatment, and, in this particular variety of illness, hardly brightening the blackness of prognosis. All I could propose was that he should abandon his project of appeal to a higher court to exonerate him from the "charge" and instead get in touch with the medical major who had promulgated the diagnosis. He consented to do so, evidently in the hope that he might persuade the major to call it by some other name.

There is no knowing from an interview such as this how extensive and systematised the ramifications of his delusions may be or how severe the schizophrenic mechanism on which they are founded. Paranoia, with or without a name, and even paranoid tendencies, are as intractable as are character traits within the compass of normality, or our beliefs, including political opinions with their minor insistences upon emotionally based ideas in preference to contrary realities. Do we not cling to these as tenaciously as a paranoiac from the cradle to the grave!

As this story is not complete without its sequel I should mention that in accordance with expectations the fiancée arrived the next day. She readily saw that the alternative to the observation ward which the man had been offered was simply that of relegating the duties of attendant and nurse to herself. I felt it necessary to point out to her that in marrying him she would be incurring the risk of finding herself united to a certified husband, with the prospect of a subsequent marriage indefinitely deferred in accordance with the nation's pleasure, however much this pleasure might conflict with her own.

I have given one illustration to show that a simple observation such as that of a patient's facies may be the crucial point of a diagnosis, and another to show that a neglect of systematic casability of may be as essential for success in some cases as a strict

adherence to it in others. No system however elaborate and complete will ever be a real substitute for experience coupled with intelligence.

With this warning let us select at random, for illustrative purposes, a fairly typical case-sheet compiled in the prescribed manner. As this, in the form of notes taken at the interview, would be rather compendious for publication, I propose to give it in the form of a letter to the doctor, particularly as in this form it may serve a double illustrative purpose.

DEAR DR. BROWN,

*Re your patient Mr. X
Aged 24; Single; Occupation, Clerk*

This patient *complains* of feelings of unreality and a number of strange subjective feelings, for instance, that he "has not got a head" and that his "real self is gone". He complains also of feelings of inferiority, that his head is muddled and that he cannot think properly; acute depression; an obsession that he will never get better; an idea that he is mad, "crazy", and numerous other complaints which he is particularly bad in formulating.

Though he puts the *duration* at about four years, he goes on to explain how he had some of these feelings as early as 16 years of age. It appears that he has been much worse in the past four years, with a temporary intermission immediately after having electric convulsive therapy, and a very pronounced relapse about eight months ago.

Family History: His father, an Austrian, died at 50, ten years ago, of pneumonia. None of the father's relatives had any nervous or mental trouble. His mother is alive aged 53. She has suffered from nervous breakdowns at least one of which, following the birth of the patient, necessitated her residence in hospital for some months. He says that no other member of his mother's family has had such a complete nervous or mental breakdown, but that they all suffer from "bad nerves" and nervous habits. The patient's younger brother died at 2 years of hydrocephalus. He is now the youngest of a family consisting of two boys and two girls. The eldest brother died eight years ago from tuberculosis; the second child, a sister, is healthy. The sister four years older than himself had a nervous breakdown ten years ago but has apparently recovered.

Past History: The patient is doubtful whether he had any infantile neuroses. At one time he says he always had nerves and nervous twitchings but later he corrected this and said he had only had them since his operations at 7, 10 and 13, all for tonsils and adenoids.

Physical Signs: I could find no signs of organic disease of the central

nervous system. He had a very slight tremor which was not constant. Optic discs and other cranial nerves appear normal. His tendon jerks were surprisingly sluggish. Blood pressure 130/90.

Conclusion: Although this man's method of relating his symptoms, or rather his genius for avoiding any statements, and indeed his entire manner and attitude to his illness, might well suggest hysteria—hysteria so acute that I can quite understand this leading to erroneous diagnosis—yet the nature of his principal complaints (feelings of unreality and the unusual strangeness of such a subjective feeling as that he "has not got a head" and his "real self is gone") points to the diagnosis of early schizophrenia, in spite of the absence of the usual auditory hallucinations.

Although some practitioners might favour a tentative course of analytical treatment, provided it was clearly understood that little more could be hoped from this in his case than a slight amelioration merely of the hysterical aspects of his illness, I myself would not wish to encourage it except to precede and follow treatment more appropriate for schizophrenia. He has already experienced some temporary intermission following electric convulsive therapy, and whether he repeats this, or resource is had to insulin treatment, I feel that the seriousness of the prognosis will not be substantially altered, and that the most that can be hoped for is recurrent remissions.

I am sorry that I would not feel justified in offering you any help in this particular case.—Yours, etc.

In my opinion it is not always necessary in every case to go too fully into too many details of matters of collateral interest. Sometimes tracing the *main* aetiological factors in a particular case is all that it is possible to do in the time available at a first interview, particularly if the patient offers considerable resistance to investigation of the relevant matters. I would even go so far as to say that a physical examination on the spot is not *always* (though usually) advisable, having due regard to the emotional state of the patient and the acuteness of his illness. It is occasionally better to leave this responsibility to another practitioner, particularly if it is clearly irrelevant to the diagnosis.

All tabulated systems of examination and rule-of-thumb guides are as artificial as, for instance, technical instructions on how to play tennis, or indeed on how best to live one's life. They may have some little value as a preliminary theoretical course for the very green beginner, but adhered to beyond that stage may become an obstacle in the path of advancement, or a stand-by for the inept who would do better to give up the subject. Art or science, like life itself—or tennis—cannot be

adequately conducted by the ego; the heart, mind and spinal cord must be in it.

The only true guide for satisfactory case-taking is a genuine enthusiasm for enquiry and research coupled with intelligence, a psychological sense and experience. The following may illustrate my meaning:

DEAR DR. SMITH,

Re your patient Mr. Y

Aged 20; Single; Occupation, Navy for the past two years, invalidated out ten days ago on account of "nervousness"; before the war apprenticed to builder

This patient *complains* of attacks of shaking, continuous pains in the head, "stomach trouble" and general clamminess (perspiration).

He says: "I don't seem to feel myself". He lies back on the settee in a lackadaisical manner as if he were suffering from extreme lassitude.

Duration: The lassitude, he says, has always been more or less present. The other symptoms are of three or four months' duration with the exception of the attacks of shaking which have only come on during the past six weeks.

Family History: Father alive, aged 60. Has not suffered from nervous breakdowns but is somewhat unstable and subject to violent tempers if upset. His mother, aged 50, gets recurrent headaches. He has two married sisters both older than himself (30 and 28), and one brother five years younger. They do not suffer from nervous trouble.

Past History: He says he was always a slightly nervous child. Though he at first denied infantile neuroses, it then transpired that he wet his bed regularly up to the age of 14 and still does so occasionally. Also subsequently I learned from his mother that he was subject to attacks of "fainting" from about the age of 2 or 3 years, but "grew out of it". No fits. He admits masturbation from the age of 14, but denies worry.

To return to his *current symptoms*: it transpires that the attacks of shaking, which have recently been occurring several times a day, consist chiefly in the most violent movements of his whole body. We had a slight demonstration of this during the interview. His head is jerked backwards and forwards and his stomach and legs are jerked up and down in a most violent and alarming manner, the whole attack lasting for about thirty seconds. At the same time he gasped for breath.

At first he was inclined to attribute his illness to physical causes, saying that he thought it was all due to his bowels being "clogged up" and then that it was all due to his stomach. Finally, I got him to consider the possibility of mental stresses, whereupon he admitted

that he thought it was due in a large part to the Navy. "I did not like the Navy too much. I was not fond of it. I have hated it particularly for the last eighteen months. . . . I did not care for the food, and finally my stomach went wrong."

In spite of his reluctance, I persuaded him to tell me more details of his sexual life. He said that before entering the Navy two years ago masturbation used to be two or three times a week, but since joining the Navy it has been very rare, only once in several months. It appears also that since the age of 14 up to the time of joining the Navy at 18, he had been in the habit of going out with a particular girl friend at least once or twice a week. At first he said that they only indulged in kissing and cuddling, and that it was an emotional strain causing him to masturbate on leaving her. Subsequently, he admitted that he had been in the habit of having complete sexual intercourse with this girl from the time he was 14 years of age (she was 12!). Contraception was usually by withdrawal (*coitus interruptus*). This sexual relationship took place on an average once a week. It was almost completely interrupted through lack of opportunity when he joined the Navy two years ago. At the same time masturbation also practically ceased.

On enquiring more closely for an immediate precipitating factor, this rather difficult patient finally told me that four months ago he received a letter from the girl, now aged 18, saying she had become engaged to be married and would not be seeing him any more.

Conclusion: There is no doubt whatever that this lad is suffering from what might be called "acute" hysteria manifesting itself in close approximation to a major hysterical fit. Though undoubtedly aetiological factors must include an inherited predisposition, as evidenced by certain manifestations of infantile neuroses, I have no doubt that the principal aetiological factor is the sudden and continued interruption of a sexual practice which had begun as early as 14 years of age and had been maintained for about four years, that is until he joined the Navy, when it was almost completely interrupted. To my mind, the resulting suppression—his sexual abstinence contrasting so markedly with the previous licence—set up cumulative nervous tension which could not find adequate sublimated discharge in his uncongenial Naval life, and finally boiled over in the manifestation of this violent hysterical symptom. I have no doubt that in the course of analysis the symptom which he calls "shaking", and which really consists of a violent jerking of his whole body, would be shown to be an unconscious and exaggerated pantomime symbolising the sexual movements (specifically those of orgasm) which have been so abruptly suppressed and which his unconscious mind has found impossible to forgo indefinitely.

The case is eminently suitable for psychotherapeutic treatment,

and as the illness, at least in its severer aspects, is so recent I think treatment should be begun without delay and before the symptoms become habitual and established.—Yours, etc.

After these two short examples of a typical psychotic and a vivid neurotic illness, we will conclude this chapter on case-taking with the suggestion that it is a very good plan to write one's summing-up of every case immediately after the interview. This is useful for reference purposes as well as for compiling the letter to the doctor.

CHAPTER IV

CLASSIFICATION

CLASSIFICATION of the neuroses is a branch of the wider problem of the classification of all mental and nervous conditions. A succession of attempts have been made to put classification upon a scientific basis.

Physical or Physiological Classifications: Though it is evident that some pathological states such as manic-depressive psychoses, some schizophrenias, involutional and senile conditions, not to mention chemically and bacteriologically induced mental illnesses, have at least factors in them which lie deeper than any discovered mental mechanism, attempts at a physical or physiological basis of classification have had to be abandoned as too little is known of the physiology of normal and abnormal mental states.

Similarly, *Psychological* classification, based on current academic psychology, merely results in showing the latter's bankruptcy when faced with the phenomena of clinical psychiatry.

Symptomological Classification: Therefore clinicians have had to fall back upon grouping their observed cases under a very unscientific symptomological classification whatever term (*e.g.* "reaction types") they may use to mitigate or disguise our ignorance of the fundamental nature of the mind in health and disease.

Classification of the neuroses, now based as it invariably is upon the *form* or symptom-presentation which a particular disorder may take, is bound to be unsatisfactory and unscientific. Though this is the general method adopted since the time of Emil Kraepelin, it should at the outset be clearly understood that it is a classification based upon the end-products of a morbid process and not upon its psychopathology or fundamental nature. These considerations are not merely theoretical, they are the outcome of the actual experiences of every clinician; for not only does every case that is investigated present some symptom or other characteristic of *several* of the neuroses, but

even during the course of treatment it is usual for a case to change its presenting symptom-picture from one classificatory type into another.

The position is analogous to that which prevailed in the world of chemistry and physics, when elements were classified as the unalterable units of matter, until further investigation revealed their transmutability and their common basis in particles of electrical energy.

Similarly we may hope that with further investigation of clinical material, so long as we do not adhere rigidly to our provisional classifications, a common basis explaining transmutability may increasingly reveal itself until the very foundation and nature, not only of neurotic illness but of mental-emotional processes themselves, may emerge and enable us to base mental phenomena on as sure a foundation as that upon which the physicists have based the phenomena of the material world.

The custom of basing a classification of the neuroses upon the presenting symptom is reduced to absurdity when we find the ever-increasing list of phobias placed in a scientific nomenclature and used as though each was the designation of a specific disorder. We now have acarophobia, acrophobia, agarophobia, ailurophobia, algophobia, amychochorophobia, to take just a few from the beginning of the alphabet! Perhaps we should now invent a name for the compulsive tendency to find names for a phenomenon in order to mask our ignorance of its nature!

I am reminded of a patient of mine who arrived at his session very much improved, momentarily at least. He said, with the first humorous twitch of his mouth which I had seen: "I have been coming to you for several months and you have never once ventured to name my complaint, and now your hall porter has just diagnosed it for me. I happened to say, 'I have not had a wink of sleep all night' and he said, O! sir, Inso Mania! I always thought I had some form of mania and now at last I know what I am suffering from."

Whatever form the presenting symptom may take, whatever variety of phobia the patient may suffer from, be it agarophobia or claustrophobia or any other phobia, the more essential point is not *which* phobia it is, but that it is a phobia; that is to say that the patient is the victim of morbid fear, morbid fear which can present itself in a hundred and one different ways, most

frequently ways which have no *obvious* connection with anxiety at all. Insomnia, for example, is commonly due to a fear of going to sleep and encountering the "dangers" within the unconscious. In this light it may be regarded as a "phobia" of sleep, or even of relaxation, an essential characteristic of anxiety.

In pursuing the quest of a truly scientific classification, as we arrive ever nearer to the basic psychopathology of all functional, nervous and mental illness we tend to find that unity is taking the place of diversity, that all the partitions between our pigeon-holes are ceasing to exist, and that, with one essential cause for all the many manifestations, the final possibility of every classification has fallen away. We have arrived at the beginning of a psychopathological process common to all neuroses, to all psychoses, and even permeating, to some extent vitiating, all so-called *normal* mental functioning.

What is the common root from which spring the great diversity of morbid mental phenomena and which forms the nucleus of every psychogenic illness, neurosis or psychosis? It has frequently been said that this common foundation is anxiety. A moment's reflection tells us that anxiety is a manifestation or phenomenon, itself requiring investigation and elucidation. It is on this account that the next section has been devoted to a study of anxiety, quite apart from its innumerable manifestations interspersed with all the constructed symptom-formations which we will subsequently consider under our various headings.

If we do not complete our investigations or reach a satisfactory solution of these problems we should not be too greatly disappointed, for it is conceivable that such a solution is nothing more or less than the "last word" which all psychological research is striving to pronounce, and that this if accomplished would mean practically the end of the journey—if not the answer to the riddle of the universe!

All we can say with certainty is that tensions accumulate in the psyche, tensions which normally obtain adequate discharge along physical and psychical paths, somatic, instinctual, symptomatic and sublimated paths; that if these tensions do not so obtain discharge proportionate to their accumulation a morbid condition arises, a condition in which ever-increasing tension must at some point no longer be possible to contain. It will break out in one or many of a diversity of directions. Why it should favour one direction more especially than another

probably depends upon the physical and psychical structure of the individual in whom it has accumulated. Our usual classification is based upon the predominating form which the majority of its outlets assume. Thus, for instance, if the outbursting tension should overwhelm consciousness and obtain a muscular discharge along the most primitive and unorganised physical routes of the voluntary musculature, the illness is classified as epilepsy. If its discharge, not quite so explosive, does not overwhelm consciousness, but nevertheless produces violent physical disturbances or actions, it may be classified as a major hysterical fit. Similarly, if this accumulating tension leads merely to periodic congestion of the brain with subjective sensations and disturbances of vision, equilibrium and associated mechanisms, it may be correctly diagnosed as recurrent migraine. A cousin to this last manifestation of illness, a relationship which is usually missed, is the periodic sensory disturbance known as trigeminal neuralgia.

Manifestations of accumulated tension may obtain their discharge along far more organised or complicated paths than the foregoing. They may cause disturbances in variations of the most delicate mental processes leading to every variety of aberration from the normal, and in a more extreme form actually seeming to divide the affective function from the cognitive as in the numerous varieties of affective disorders, schizoid states and schizophrenia.

Thus we see that until the problem of anxiety reaches its final solution we may have to rest content with a classification of neuroses based upon the very arbitrary selection of the main grouping of their symptom-presentations. This, if it tells us little or nothing about the essential elements of the disorder, tells us at least something of the picture which it presents to the majority of us who see no deeper than the surface. And so we continue to classify the neuroses not as the molecular physicist would classify matter, nor even as the chemist would classify the once "unalterable" elements, but rather as the most superficial observer would classify the phenomena of nature into earth and air, fire and water. There may be little harm in this provided we recognise that we are naming superficial manifestations only, and not, in our nomenclature, claiming any deeper insight into the nature of disease.

"More than that, even when you cover this hair with your clothes, you still feel that the shameful thing is visible in what you choose to regard as your manifest homosexuality. Nevertheless, you are still on the same tack, endeavouring to remove what is nothing more nor less than a symbol of that which you wish to conceal, eradicate or cut off."

"X-ray treatment is the only thing that would remove it. But such methods would avail you nothing. However successful you were in removing that hair permanently, your complex would remain, and you would still feel that the shameful thing within you was revealing itself one way or another."

In the rather hopeless task of getting such a patient to recognise at the first interview that his "complaint" was merely a symbolical representation of the inner and hidden complaint or complex, it had inadvertently slipped out that there was a physical treatment which could remove the hair on his back.

I noticed as I mentioned X-ray therapy that his eyes suddenly lit up, and it was particularly on this account that I was not surprised when he made no further appointment with me. I had a very shrewd idea as to where his next guineas would go.

It was some six months later that this man again communicated with me. In the meantime he had undergone treatment which had partially denuded his shoulders of hair and had occasioned an odd contrast between this part and the rest of his hirsute body. He was just as worried.

He showed some resistance to relaxing upon the settee, but once there it was evident that he had a great deal of which to unburden his mind. At the same time he protested that it was against his inclination to delve into his past life, as he would much rather leave that a closed book, and have a physiological (glandular) cure for his present and future difficulties.

In accordance with this idea he emphasised his theory that there was something physiologically wrong in his make-up and that he was very sceptical about psychological treatment being of any use to him whatever.

I said absolutely nothing, because it was quite unnecessary. In fact, nothing would have prevented him from plunging straight into all his past, accumulated, psychological conflicts and difficulties, including a detailed story of their chronological development.

Presumably his theories, together with his original determina-

tion to remove his hair by physical methods, as well as the form this complaint took, were merely the expression of the defensive elements in his mind against the impulses and urges which he had long endeavoured to repress. However, we were at the moment concerned with un-repressing them, and bringing the whole matter up to consciousness.

He began with a story of some heterosexual play of infancy which had led him to masturbation from the age of eleven to fifteen. He said:

"Curiously enough this coincided with a period of church-going and deep religious fervour for one so young.

"Nothing seemed to happen until just before the age of sixteen. I seemed to get an extraordinary revelation. I can only compare it with the sort of revelation which St Paul writes about at the time of his conversion on the road to Damascus. I can still remember the occasion. I was riding on a bus at the time, and looking through the window at the beautiful world without.

"I suddenly seemed to realise that everything was beautiful, that all people were 100 per cent. pure-minded and, at the same time, that there was something revoltingly ugly within me. It seemed to give me a terrible shock, and from that moment I cut sex clean off.

"I admit that subsequently I had some difficulty in maintaining this thesis of 100 per cent. pure-minded world. But I did maintain it. For instance, when I saw advertisements about books about sexual knowledge, I decided that they were just catchpennies for a world that knew nothing of such matters. I stuck to it that people had no interest in sex whatsoever—and no desire for it."

Such remarks as these, by the way, are frequent enough in the experience of the medical psychologist. A colleague of mine still relates the incident of an intelligent adult who, during his analytical session, remarked that sexual intercourse took place among animals and had been known to occur in the East, but never in any civilised country. It was only when he had been made to reflect upon this remark that he began to suspect that there was something wrong somewhere!

The general attitude of most normal people to this subject is a compromise between this extreme idealisation and the facts. The person who is obsessively occupied with his own sexual

impulse commonly goes about in his outward life pretending that sex is of no importance, and emphatically denying the sexual theory of the neuroses.

The patient continued:

"I started off by thinking I was the only one who had been wicked enough to indulge in sexual feelings at all and that there was nobody else in the world as wicked as I was. Anyway, I put away my masturbation and gave up all sexual experiences. I have never indulged in them since."

"It was some years later that I got to know a youth five years my junior to whom I was much attracted. His parents kept an hotel at a holiday resort, and it occurred to me that I should like to spend a holiday at that particular place. I don't think it was the fact that he would be there that attracted me. [He really said that.] Anyhow, I fell in love with him.

"He was one of those girlish-looking youths, smooth-skinned and *without any hair on the face*, who still attract me. For a long time I thought more about him than of anything else. He monopolised my whole life. The only time I lived was when he was near me. Anyhow, we took a flat together.

"It proved a most unhappy experience. I had thought that my feelings were purely mental and spiritual, but living with him I discovered that they were physical as well. The experience was unhappy because I was determined never to tell him. After two months of this I got appendicitis, and that rescued me from the unequal struggle.

"It was shortly after I had fully recovered from the operation that my present worry about the hair on my back arose. I can remember the occasion most vividly. I was in a bathing tent at the time preparatory to going for a swim, which I have told you was a recreation I particularly enjoyed. I was undressing when I saw this hair in the looking-glass.

"Of course, it must have been there for many years, but on this occasion it gave me a terrible shock. Instead of going swimming I hurriedly got dressed and came away. And I have been careful to conceal it ever since."

ANALYST: "*What did the hair betray?*"

"I suppose you mean it betrayed my homosexuality."

ANALYST: "*If you had seen a cloven hoof or barbed tail, what would that have shown?*"

"My abnormality."

ANALYST: "If it were horns sprouting under your hair, what would that have given away?"

"You mean in addition to the horns themselves?"

ANALYST: "Yes."

"My Satanic quality—my sexual life of school days."

ANALYST: "Was it homosexual then?"

"Well, if it was I didn't think of it as such. I later (at fifteen) thought of it as wickedness in a pure world."

ANALYST: "That is when you 'cut sex clean off'?"

"Yes."

ANALYST: "And wished to become pure and good and smooth like the rest of the world?"

"Yes"

ANALYST: "Without any sexuality?"

"Yes."

ANALYST: "Without any hair on your body, and further, without any masculinity, and particularly without any sign of it such as visible hair on the face?"

"Most emphatically."

ANALYST: "In fact, as smooth-faced as the girlish youth you fell in love with?"

"Yes, that is what I would have liked to have been like"

ANALYST: "And that is why you liked that youth, and that is why you nurse the illusion that you betray homosexuality or femininity. But even this, which is the negative side of the picture, seems to you to betray the very positive thing which you wish to conceal, or to cut clean off"

"And when you see hair growing on your body it is just as though the horns had sprouted through, despite all your endeavours to repress it, and so betrayed your wickedness to the world."

"And so you wanted me to aid and abet you in eradicating this most recent irruption of that which you had tried to eradicate at the age of sixteen

"You cannot solve your problem by cutting nature off, or you would have to cut your whole body off and become a spirit. You will discover that you have to find some other solution"

Psychopathology: We can best illustrate the psychopathology of this case by dividing the mind into its three main topographical divisions. Indeed the patient's illness is due to just such a dissociation or division of his own mental ingredients into three distinct and even opposing and conflicting parts.

The first part we may call "*Body*"; the second, a little later in development, we may call "*Anti-body*"; the third, which is much later in development, and for which very little space is left, we may call "*Common Sense*". Psycho-analysis has termed the first the "*Id*", the second the "*Super-ego*" and the third "*Ego*".

Now, the "works" begin with the activity of the body. It was physical impulses and feelings which were responsible for the masturbation activities. These went on for some years, like every other body function, unhampered by any opposing force.

However, the opposition had apparently been accumulating in its own separate compartment, and it was at the age of fifteen, while he was riding on that bus, that it suddenly came into contact and conflict with the years-long established masturbation.

As the body had been indulging itself in all its manifold activities, including growth and the satisfaction of instincts, so those anti-body forces had evidently held their head very high above all such things. The more extreme the one was, the more extreme and dissociated became its counterpart in the course of its development.

Thus it was that day on the bus this youth of fifteen suddenly pictured the world as 100 per cent. pure, that is to say, with absolutely none of these physical or bodily things.

This striking antithesis shows how drastically he had divided these two portions of his being, and how inevitable must be the conflict between them which was to pursue him throughout his life.

This antithesis (and the resulting conflict) is the essential mental origin of all psychogenic illness and in its most extreme and unconscious form it is particularly characteristic of schizophrenia.

However, he had projected the "anti-body" one on to the world outside, and regarded *himself* as the unfortunate embodiment of all that was base and undesirable. [A preference for the antithetical selection is more common (e.g. paranoia).] This would not do at all. It could not be tolerated. Therefore he had "to cut sex (or body) clean off".

You see, otherwise he would not have been able to love himself at all. Or rather, his anti-body part (conscience or super-ego) would not have been able to love him. This alternative, the equivalent of no love, would have been death.

"If thy right hand offend thee, cut it off and cast it from thee,

for it is profitable for thee that one of thy members should perish, and not that thy whole body should be cast into hell."

Accordingly, this youth "cut sex clean off". But sex, like every other portion of the body, is an irremovable part of a bodily whole. The body will not lie down to such treatment from any dictator while there is any life in it. While there is life, it will unceasingly be striving to reassert itself in one form or another. Hence the conflict or war within the mind will continue interminably until death.

The battle may sway first to one side and then to another, but conflict there will always be. The poor ego, or common-sense member, will find itself buffeted about and coerced first by one of these powerful fighting forces and then by the other.

At sixteen the patient thought he had won on the side of the super-ego (100 per cent. purity) by "cutting sex clean off", but the victory was, of course, incomplete. Masturbation undoubtedly cropped up at more or less frequent intervals, in spite of super-egos, however strong. All that was certain was that the war continued.

But in so far as sexuality was unduly beaten down by these opposing forces its libidinal energy found other forms of bodily expression, and through them other ways of getting its own back. The growth of hair, or rather his compulsive mental concentration upon it, was no doubt just such a one. This in turn caused similar worries to those of the compulsive masturbation impulse, and a similar wish on the part of the opposition "to cut it clean off".

Finally we get to the stage when he sees the figure of a youth symbolising what he himself would have liked to have been—smooth-faced, and symbolically sexless, or "100 per cent. pure". It is this 100 per cent. purity which he loves or thinks he loves and cannot have too much of. Therefore he proceeds to share a flat with the pure one.

But again he finds that in the pursuit of these ideals he had reckoned without his host—the body. Up crops the hated demon of impurity once again, and to his horror he finds he is having physical, sexual phantasies, desires and impulses towards this symbolically pure, love object.

Evidently at this stage the conflict became so severe that real physical things went wrong with his body—physical things which fortunately saved him from an impossible situation. He

got appendicitis. Again there was a cutting-off, or cutting-out, of a portion of his body. This time a real portion was cut off with a real knife. Anyhow, that ended it . . . for the time being.

But while there is life there is hope—at least, so the body seemed to feel, for it persisted in plaguing him, its oppressor, with its undesired growth of hair in one place or another.

It is not without some significance that he discovered this unwelcome irruption just at a moment when he was going to indulge himself in the physical enjoyment of swimming. Swimming often appears in dreams as a symbolical expression of the sexual act, particularly of the unconsciously incestuous sexual act.

The guilt, which was not far beneath the surface, pinned itself on to the hair which he saw in the glass in his bathing tent; and not only guilt, but also anxiety of its revelation. That finished swimming, as his 100 per cent. purity had finished masturbation, and as his appendicitis had finished homosexuality.

Well, hasn't he had enough of all this? Oh, no! No conflict is solved by the diametrical opposition of two portions of the mind. Unless they can get on speaking terms with each other and reach, if not fusion, at least toleration of each other, the fight will end only with death.

This patient, in his endeavour to be 100 per cent. mind or spirit, comes to me with what he feels to be one or two intolerable blemishes. They are, of course, all one and the same thing. Only he does not call them by that simple name. He calls them hair on his back and "slight homosexuality".

It is not so slight as to be possible for him to forget it. He thinks, indeed, that everyone he meets can see it, as though it were the first thing or the most important thing about him.

Why doesn't he call it "sexuality"? Well, sexuality leads to a certain complete act, and he could never, since fifteen, have been so frank about his body and so tolerant of it as to accept such a tendency. This sort of frank bodily thing has got to be "cut clean off".

That the "cutting-off" was not so complete and clean is shown by its reappearance in a lesser form called "*homosexuality*", and even then the lesser nature of the "crime" is emphasised by prefixing still another word, "slight". At the same time this twist (*homo-sexuality*) gives the ego an excuse

to join with the super-ego in carrying the war into the enemies' camp.

Thus he is not the little Oedipus criminal, but merely a would-be pure gentleman with a "slight blemish". And this remaining "defect" he is spending his life endeavouring to eradicate!

There is much in common between the psychopathology of this case and that of all so-called normal individuals. Everywhere the ego's chief preoccupation is hypocrisy. That is why it is so powerless to intervene in the conflict between body and conscience; indeed, through the repudiation and repression of the former by the latter, a great deal of this conflict remains unconscious; the basis of psychoneurosis (anxiety and hysteria) is firmly laid and maintained; the ego's relationship to reality is impaired (psychotic or psychopathic trends); the modicum of sexuality that emerges from repression is twisted into a narcissistic, homosexual form; and, where the conflict is most severe and where the libido in consequence regresses to the earliest fixation points, a schizoid mechanism is activated. Thus we see that even a near-normal, psychopathic conflict can initiate elements of almost all the neuropathies and psychopathies and reveal the impossibility of attaching rigid classificatory labels (so long as these are based on symptom-presentation) to even the simplest case of morbid, mental conflict.

SECTION II

THE PROBLEM OF
ANXIETY

CHAPTER VI

A SPECULATION ON THE NATURE OF ANXIETY

In a previous book¹ I said that anxiety is the raw material out of which all neurotic symptoms are made, and the relationship was shown between the normal reaction of fear to an external danger situation and the reaction of morbid anxiety to an internal "danger" situation. As we propose in this book to carry our studies to a more advanced stage, a word should be said about how this internal danger situation, the precursor of anxiety, itself comes into being.

Here it seems to me that we approach the borderland between psychology and physiology. There is evidence that the life-process contains physiologically something which can only be expressed psychologically as a state of increasing tension—physiological tension preceding mental tension.

We can illustrate this concept by taking as an example one of the simplest forms of life, for instance the amoeba. This, a unicellular animal in the process of ingesting increasing quantities of nutritive material, eventually reaches a size at which it begins to change and form two amoebae. The latest view as yet substantiated is that the initial event consists of a dip or dimple forming in one part of the surrounding cell membrane and reaching down approximately to the nucleus, which then begins its changes. Biologists say that there is an increasing "turgor" in the growing cell. This they define as a state of "turgidity" or tenseness. It is presumably this which initiates the changes in the cell, and in its nucleus, culminating in cell division.

The problem we may consider is what is the internal state of that amoeba *just prior* to the commencement of cell division. I feel that the biologists must be right and that we cannot resist the deduction that a state of *tension* exists within it. Since the canon of all science is that there is no effect without a cause, we must assume that there was *something* which had not previously

¹ *War in the Mind*, 2nd Ed. p. 13.

been there, or which had not previously been adequate in intensity, to initiate this physiological process of cell division. That "something" was tension, increasing tension, finally reaching a point at which cell division (reproduction) begins. We do not know whether the amoeba *feels* anything, but if it could feel, on the analogy of our own subjective experiences, it would be natural to assume that it feels tension—perhaps some degree of increasing discomfort. Anyhow, the splitting or division begins to take place.

Now we have only to go beyond the realms of physiology and suppose the amoeba possessed (which it presumably does not possess) a force or mental quality within it opposing this physiological process of splitting or of reproduction. In so far as this latter force was at all effective we would have to assume that it was sensitive to the increasing tension or discomfort which it was actively preventing from resolving itself into physiological activity. Thus we would assume that, as the tension within the cell increased, this secondary mental quality would experience, or have cognisance of, the increasing discomfort. We would also have to assume that the accumulation of energy (tension-energy) being prevented from translating itself into cell division would tend to leak out in other forms of activity (cf. symptoms). At the same time as this "mind", resisting the translation of energy into physiological activity, felt itself to be threatened by the increasing pressure of the opposition (nature's opposition) this mind would have reason to fear that at any moment it might be overwhelmed, brushed aside as it were, by the forces of nature.

Man, neurotic man, who has opposed his instinct-pressure, is in this unfortunate position. Thus he may be the victim of two sources of discomfort, tension and anxiety. The increasing instinct-pressure within him, finding its outlet or its translation into physiological activities blocked, would thus be a source of discomfort analogous to the increasing tension within the cell membrane of the growing, but not-dividing, amoeba. This would be one source of discomfort, a physiological one, appreciated mentally. The other source of his anxiety might well be a fear on the part of his ego that its efforts to control the ever-increasing pressure of nature might at any moment be brushed aside.

There is evidence that an anticipation of this sort on the part

of the ego, the anticipation of being overwhelmed by forces over which it no longer has control, is interpreted by it as a threat, not only to its powers of control but to its very life and existence. It is as though the individual thought, "If I lose control I am lost—I am no more". Thus it summons all its energy to further efforts in the losing fight. It may not yet have lost, apart perhaps from minor defeats, but it is in the throes of the most awful anxiety.

It is not suggested that the animals, from the amoeba to the mammalia, have consciously elaborated a true philosophy or arrived at a true appreciation of reality which we could not do better than accept and emulate! But I would say this for them. They have not arrived at a false one.

Their instinctual urges which they accept without question are true for them and true for their reality experiences *so far as these go*. The only frustrations which they will encounter exist in the real world around them and they will use every ounce of their energies, instinctual *and* ego energies, to overcome these frustrations and to modify the real world around them to suit their instinct requirements. Unfortunately for them their capacity to manipulate reality is particularly limited, but in the wild state, they have insufficient super-ego, to pit an elaborate distortion of reality against their instincts and to create frustrations, conflicts and neuroses within the psyche itself.

This last is commonly the condition of the patients who come to us for treatment. It seems futile to say to them "Why, you have only to step aside and leave the thing to nature which was there long before you were, which created you in its womb and which has maintained your life and health ever since, long before you in your stupidity presumed to interfere and try fruitlessly to take the matter out of its hands."

"Cannot you appreciate that you were not consulted at your making and yet you came into being, not into destruction? Cannot you appreciate that the forces of life are aeons older than you are, that they made you and used you and still flow through you as they do through all their creations, urging you and compelling you with irresistible insistence that you must obey their will and fulfil their purpose? Nature is using us all in its evolutionary fulfilment whether we wish it or not. There is no successful gainsaying her. All you can succeed in doing is putting your feeble little ego in her path and fearing, as well you have

reason to fear, that she will brush the puny little new-growth aside. Your ego was never created for such a purpose. Your ideas or ideals are not comparable to the purpose of nature which you are incapable of understanding, leave alone of drastically altering or reconstructing.

"The most that your ego can do is to harness itself to these great forces aspiring to be their servant, not their master. Nature's purpose will be fulfilled whether you wish it or not. Object, and you will be destroyed or at the best filled with anxiety, discomfort and unhappiness. Acquiesce and you will be carried forward with all the exhilaration of nature's forces buoying you up."

Unfortunately this thesis, however readily accepted by the anxiety-ridden person's ego, is ineffective in removing his anxiety-ridden resistance to his primary urges. It would appear that there is some buried force inaccessible to his reason which is unconsciously creating the condition of intra-psychic conflict or war within his mind. Throughout his life and possibly even prior to his individual existence, resistances to the natural law of his instincts had been accumulating to a degree far in excess of that demanded by the realities around him. The structure is largely an unconscious one belonging to the forgotten past. He, or his reason, is powerless to alter it. What is to be done?

This is where analytical psychotherapy comes into the field. By the technique employed this unconscious, repressing structure is gradually brought into consciousness where the forces of the patient's adult ego and reason are for the first time in a position to deal with it and destroy its power to wage this hopeless fight against nature's legitimate and inexorable pressure. *The reality sense should be all that is necessary to prevent instinct from destroying the individual or/and the society in which he lives.* The forces which irrationally and unduly attempt to dam up his instinct-drives are of a distinctly lower order. They lead to a state of anxiety, but not to any really successful adjustment to reality. Hence, while he wages war against what he considers to be the destructive power of instinct-pressure within him, he meets his destruction in spite of his fears, or rather because of them.

Analysis of the mind enlarges his ego, or reality principle, at the expense of these irrational warring elements. It extracts the energy which is being absorbed in them, and in their symptom eruptions, and makes it available for the use of his ego. Thus his

ego grows and is strengthened at the expense of the forces maintaining his neurosis.

This is a process by which we may hope to bring the irrational forces of his unconscious mind into contact with his conscious ego and reason. What he will then be able to do with them is limited by the nature of his ego or reason and whether or not it, itself, is properly adjusted to the realities around him.

So the purpose of this book is as far as possible to deal with this ego or reason. Before this can be done it is necessary to draw attention to the fact that all is not reasonable within the reason, that reality has been misinterpreted by man's ego and that in his manipulation of it he has insufficiently taken into account the nature of his own internal reality, of his own instinct nature. In fact, his ego is a distorted and diseased structure and a very important obstacle to the successful adjustment of himself to reality and of reality to himself.

In short, it is not merely a neurosis from which he is suffering, though it is the main purpose of this particular book to draw attention to his neuroses, but it is also, and this is of far more serious import, a psychosis which has him within its grip and into which, as is the case with most persons suffering from a psychosis, he has little or no insight.

We shall come back to this at a later part of the book. In the meantime I propose to give a series of case-sheet extracts to draw attention to the operation of anxiety in human life—*anxiety* or more fundamentally *tension*, the raw material out of which all neuroses are made. I shall begin with the case of a man who in the ordinary commercial world passed amongst all his friends and acquaintances as normal and successful. We will see what is going on behind the efficient cover of this normality and success. Further, it will be pointed out that this is only a more pronounced degree of what is going on in all of us, in practically every human being. There is constantly some degree of morbid anxiety in every normal life. I have not selected a person who is in this respect very much out of the ordinary. I am merely throwing into a slightly higher high-light something which in some degree, operative or inoperative, lies in every one of us under the normal social and ideological conditions which we have created for ourselves with our usual failure to appreciate adequately what we were and what we really are under the surface.

CHAPTER VII

THE PROBLEM OF ANXIETY

✓ANXIETY, the most fundamental and universal of all nervous and mental symptoms, has no reliable, magical cure. The truth of the matter is that before we can rely upon fully curing any nervous or mental symptom, even anxiety, we must understand it. That is the tenet of all science and the essence of the scientific method. In attempting to understand anxiety we are led to investigate it. The more we investigate the more our investigations lead us into wider fields—unbelievably wide fields—until eventually we find that we have the whole problem of the universe to deal with.

To the scientist this should not be surprising. He has come to the same conclusion in whatever field he has chosen especially to pursue his investigations. At whatever point he begins his researches, if they are scientifically genuine, he is led to realise that all problems are ultimately *one*. There is only one riddle, and mankind has not yet reached its ultimate solution.

This section on the Problem of Anxiety will lead us eventually into a consideration of the most fundamental problems of life and death. In the meantime the investigators, in this case therapist and patient, have the consolation that certain minor problems are solved on the way and that betterment, if not complete solution, satisfaction and cure, can be gained by the wayside. First—and perhaps also last—we must examine the data of observation, the clinical material *in statu nascendi*.

CASE.—(1) A healthy-looking and vital young man, the only son of his beloved and over-anxious mother, consulted me on account of the fact that the well-meaning prescription of his family doctor had failed to alleviate the acute anxiety symptoms from which he had suffered almost throughout his life.

This well-meaning prescription was rather a large and expensive one—it was marriage.

The danger of half-truths is frequently being emphasised, and at the outset it may as well be admitted that this prescription

contained a half-truth. Had the young man been well enough to utilise the marriage situation for the achievement of full and adequate orgasmic potency, a considerable amount of relief, at least, would have been achieved. Unfortunately he was already too nervously ill to achieve this result—notwithstanding the fact that he looked physically in the pink of condition and habitually indulged in the most strenuous athletic sports.

At the interview he took a considerable time to come to the point of enunciating his symptoms. As I prefer to give these as far as possible verbatim, the reader must excuse me if the recitation, like that of the patient, is somewhat disjointed.

He said: "It is now two years since I married. The doctor thought that would cure everything. I suppose it should have done, but it has not. That is not my wife's fault. She is a most sensible and understanding person; everybody, including my mother, thoroughly approved of my marrying her. To tell you the truth, I think mother really chose her for me. I was rather nervous of women and would surely have gone wrong. So that is not the trouble."

ANALYST: "What is the trouble?"

"I get fears about things that are absolutely childish. With a great effort I conquer one of these fears, but almost immediately I pick up another. It is perfectly senseless, but do what I can, I can't help it.

"I conquered my fear of going into a train, but then immediately I got a fear of heights—could not even get up to the second floor of a building. And if I conquer that I get some other fear, for instance about my heart, or even in the absence of these things I get just a *feeling of fear*, a panic over nothing, and then I cannot tack it on to anything.

"I am afraid of it coming on at any time unexpectedly. I would call it a fear of fear. I am constantly in a state of impatience. I suppose one might call it a state of tension all the time. I always want to know where my mother is so that if I get in a panic I can rush home to her. I feel that she will understand and then it will be all right.

"I do not think I sleep properly because I dream the whole night long. Though I do not drink to speak of, and though it would not bother me if there was not such a thing as alcohol, I know from experience that a drink can relieve my tension, and it would be quite possible for me to become an immoderate

drinker. I am glad to say I have successfully resisted that so far.

"Oh, yes, I get physical symptoms too. Though I know I have not a weak heart, I think about it and get palpitations and then I get into a state of panic. At the slightest thing I break into a bath of perspiration. My hands are always perspiring. Sometimes in bed I get trembling feelings which seem to start in the stomach and go down to my legs. Also I suffer from a pain behind the eyes. Though I still play football when well enough, I am often laid up with rheumatism and lumbago.

"Another trouble I have always suffered from is a very acid stomach. Then there was my chronic appendicitis. After years of that they had me X-rayed. I was told the appendix was bad and finally I had it removed. That was about four years ago. I thought that having an operation on the appendix might have some effect on the acidity, but I still went on having it just the same. I think after two more years my doctor got tired of me and came to the conclusion that all my troubles were a neurosis. That is why he advised me to get married."

The story was taken up at subsequent sessions in the following words: "I have had no sexual experiences before marriage, that is at least apart from some childish things as a boy.

"In a way I have got the impression that my whole trouble is connected with sexual matters more than with anything else. I have got very depressed at the thought of that. I have felt I wanted to forget it, to push it out of my mind. I suppose that has been part of the trouble all my life. I have been a bit afraid of things—if that is the right term—inwardly, but not outwardly.

"I mean I have had normal feelings of attraction toward the opposite sex, but I never dared to let anybody know about it. That reminds me that for a long time I did not want anybody to know that I had these fears and still I am very shy and secretive about them. I have always been afraid of the consequences of sexuality, and I think that is why I had had no experience before marriage.

"Of course, I have had other fears too, even fears that I could not tack on to anything. Sometimes at night I would wake up in a panic. If a strong wind were blowing, or it rained very heavily, I would be in a dreadful state with palpitations and almost with asthma.

"I hid it for a long time. Then I tried physical culture. I took it up very seriously. For a time I did feel a bit better, but I

think that was only because it diverted my mind from sexual matters. I always wanted to master sexuality, to fight against it, because I felt that it was wrong, but I do not think I ever really succeeded.

"I was a nervous boy, rather highly strung and top of the class, but my phobias only really came on properly when I was fifteen or sixteen and they tacked themselves on to anything and everything. Perhaps it was because of my sexual struggles at that time that I got the impression that the trouble was connected with sexual matters more than anything else, and perhaps that is why the doctor thought I ought to get married, and that is why I felt he might at last be hitting the nail on the head, in spite of the fact that secretly I was afraid of the idea.

"That is expressing it inadequately. In anticipation I thought I would panic at the wedding and bolt when it came to the point. But I told myself that this was just another one of my silly phobias, and so I made myself go through with it."

ANALYST: "But now having got married, what makes you cling to the idea that your trouble was connected with sexual matters more than with anything else?"

"Well, the anxiety shows itself there too I suppose I have so much tension or anxiety that my function seems in too great a hurry. I try my best to control it, but I have not succeeded yet. Although I have been married two years and although I have the greatest affection for my wife, she does not attract me so much as other women in that respect."

ANALYST: "Do you achieve sexual intercourse at all?"

"I did not at first, but I am not quite so bad as that now. Nevertheless, I should admit that it is usually over almost before it starts and then I feel worse instead of better the next day. On one or two occasions when it has been more satisfactory I have been better, and the symptoms have been better, the next day, but this hardly ever happens."

In short, this patient is suffering from premature ejaculation, perhaps the commonest symptom of anxiety state and certainly the most fundamental. It means that he does not achieve full orgasmic potency.

The importance of his constitutional inability to achieve this cannot be over-estimated. It has been said by a post-psychanalyst¹ that full orgasmic potency is the criterion of nervous

¹ Wilhelm Reich

health and vice versa. Nevertheless, it is significant that the orgasm has remained the Cinderella of the natural sciences, and has never been adequately investigated by scientists, doctors, biologists or even by sexologists.

Presently we shall turn to some later clinical material to underline the above-mentioned theory. In the meantime we shall consider some earlier clinical material in the direction of investigating the psychopathology of this patient's sexual anxiety.

Clinical Material: The patient brought me the following dream: "I was driving a powerful car. My mother, my wife and another girl were in the car. We came round a corner to a level crossing. A train, all lit up—a sort of flame colour—was approaching. At this point I felt I was blind. I said to the girl, 'Am I getting near it?' I had an awful struggle to pull up.

"Then we heard that a certain boy whom I had known at school had died. He was lying on the grass beside the level crossing. He had been killed by the train. The girl who was with us was very distressed about it. I said, 'Surely you don't know him?' She said she knew him very well indeed.

"Somebody said, 'Aren't you going to do anything about it?' The odd thing is that what we did about it in the dream was a sex act with immediate emission!"

In free association of thought with regard to "the girl" he admits that she has attracted him more than his wife, but continues: "These intrigue-desires are kept well within social limits. I seek the situation and the desire is there, but I keep it well inhibited and certainly make no approach; although, to tell you the truth, perhaps I should claim no credit for that as I am practically certain that the slightest attempt would immediately lead to this prematurity."

With regard to the particular schoolboy, he says: "He always had to be excused from class at any time, because he could not control his bladder." Further association leads to memories of his own difficulty in controlling his visceral functions as a boy. He says that he frequently dreams that he is driving a car and is blind. His association to this is "inability to control orgasm".

To cut a long story short, the interpretation of this dream is that it represents his sexual act. In this connection it is noteworthy that his mother is in the car—with the girl representing a sexual attraction and the wife possibly as an intermediary—part of the one and part of the other.

"Round the corner" is an anatomical allusion to a sexual manœuvre. It is then that danger arises. A flaming train symbolises acute sexual excitement coupled with intense anxiety and may be a projection of childhood fears of parental sexuality, symbolising specifically the paternal phallus.

It is noteworthy that it is at this point that the dreamer feels he is blind, that is to say, feels he has lost control as this patient does in his symptom of *ejaculatio praecox*.

In connection with "I was able to pull up", he remembers that on an occasion just prior to this dream he had successfully forestalled the tendency to prematurity by keeping perfectly still. But at that point he lost his potency—and the dream tells us, firstly that he "felt he was blind", and secondly, that the "boy had died and was lying in the grass beside the level crossing".

This involved the patient in a condition of distress (in the dream, projected on to the girl) and an urgent need to do something about it in the shape of reviving sexuality. This he succeeded in doing only to experience his usual premature ejaculation.

Thus we see that the apparent oddity at the end of the recounted dream is no oddity at all, but only the significance of the dream at last escaping the censor and coming belatedly out into the open.

The points of interest are the suggestion of incest phantasy (the mother in the car), strong castration phantasy (the expected collision with the train) intimately related to his habit of sexual inhibition, and, finally, the attempted restoration. This last reveals that his sexual act is not so much a response to pleasure urges, but rather a compulsive attempt at restoration, or an attempt to negate the unconscious phantasy of castration by an effort to achieve potency.

Here we see signs of what might be called the ego, the willing conscious mind, taking a hand, a commanding hand, in what should be an automatic response to pleasure urges. The former is activated by anxiety, the latter by pleasurable feelings; the two are antitheses, incompatible with, and destructive of, each other.

Any conscious interference with the automatic function of the body at, or during, the stage when it should be left to its own resources is damaging to that automatic function.

There is little doubt that this patient has instituted such damaging interference from a very early age indeed. The cause of such interference is always fear, either from outside dangers or from inside anxieties, and fear or anxiety are incompatible with healthful sexuality.

Other dream material, which we have not space to record here, brought to mind many infantile memories showing the inauguration of these injurious influences.

For example, at the age of four this patient, perhaps already inclined, through inordinate mother-love, to be a little sexually precocious, was caught when investigating a neighbour's female infant. Castration threats were poured upon him by both the little girl's mother and his own.

Subsequently, at his private school, he became the victim of similar curiosities at the hands of a bigger boy. These advances stimulated in him both genital excitement and considerable fear and conflict simultaneously.

No doubt this was the sort of thing which in its multiplication inordinately stimulated both his sexual impulse and his anxiety, coupled the two together and produced a state of conflict even greater, or more intense, than that from which the majority of persons suffer.

Loss of control instead of being a pleasurable experience, as it should be under appropriate conditions, is symbolised by him as going blind when about to dash into a flaming train and is accompanied by an anxiety so great that the automatic pleasure-giving and health-giving reflexes are prevented from natural function.

The result is that, even if physiological emission does occur, it happens before adequate nervous tension has been mobilised and prepared for satisfactory relief or reduction of his super-abundant tension. In consequence his nervous system is for ever piling up tensions which it cannot sufficiently relieve on account of the interference of the normal mechanism for relief. This is the formula for all anxiety states and for all nervous illnesses.

These tensions having been unable to gain physiological pleasurable outlet, then accumulate in various parts of the mind and body, causing the symptom of acute discomfort therein, until they can be held no longer; then they automatically find discharge through paths which were not designed physiologically for their discharge. They cause, for instance, increased glandular

and muscular activities in any and every part of the body, with or without mental alarm at the inability to control them. These are the symptoms of the Anxiety State.

Physiological Aspects of the Problem: Such cases as this with an abundance of physical as well as mental symptoms should serve to remind us that body and mind are not separate entities functioning independently of each other, but that, on the contrary, they are one integral organ, one indivisible whole.

If proof of this is required we need only trace the transition even during an analytical session of a mental symptom into a physical symptom and vice versa. For instance, this patient, doing his so-called free association of thought and demonstrating his characteristic lack of freedom, not only in the hesitancy and blurring of the thought material, but also most markedly in his manner of speech, his clumsy difficulty in getting out even one coherent sentence, announced towards the end of an hour that he had succeeded only in giving himself a violent headache.

This would not surprise any listener who was at all eager to acquire information from him, for he too would almost certainly be suffering from a headache in very much less than an hour!

Unless one is accustomed to listening to this manner of speech it is not easy to understand what I mean. I can only describe it as a sort of "*mental stammer*", a stammer of the mind and perhaps of the sentences, rather than the familiar stammer of word pronunciation. This mental stammer is produced by the presence of conflict between the wish to express on the one hand and inhibiting forces which interfere with and deter this purpose on the other hand. The result is that tension fails to be relieved by speech. On the contrary it accumulates behind the unexpressed, or unsatisfactorily expressed, thoughts and sentences.

The absence of satisfactory expression finally results in this dammed-up tension overflowing along what are called somatic (bodily) channels and giving rise to physical symptoms (such as the headache) instead of to release through the medium of words.

It occurred to me to say to the patient that his powers of expression were inadequate to relieve his tension, that perhaps any amount of even successful verbal expression would be inadequate to relieve the quantity of tension which he had accumulated, that perhaps orgasm alone would be adequate to relieve it.

me unsatisfied and more nervy than I was before.

"It seems to me that I must try to control this hateful happening, though I admit that I do not try to keep away from sexually stimulating situations. On the contrary, I am for ever seeking them."

With reference to this dream material it should be emphasised that the dream occurred more than ten years after the events of seventeen years of age to which it is related. When he brought me the dream he had at first no idea that it was connected with these early events. He had just been exciting his sexual function and at the same time preventing it from relieving the tension which this excitement caused. Immediately after he experienced his first acute phobia of travelling by train, an experience which has ever since prevented him from using this means of travel.

The identity of the stations referred to in the dream with those of the real journey when this phobia was first experienced shows without doubt that the dream has direct reference to the events of that very distant time, events which were related in time to the sort of sexual practice constantly associated with anxiety neurosis.

The psychopathology of this anxiety situation is as follows: The patient, like everybody else, inherited the capacity for a normal sexual instinct. The normal pattern of the sexual impulse is for it to progress through increasing tension to its final aim, orgasm.

While this patient has encouraged the first part of this instinct pattern, namely, the stimulation of sexual excitement, he has deliberately interposed his ego in the way of its natural sequel, namely, the orgasm. He lets the impulse go half-way because so far he feels he has control over it; his ego is in the position of an outsider watching it.

When his sexual impulse has gathered strength and momentum and is inclined to sweep him along with it—at this point—he gets frightened and tries to stop it. It is as though he interposes his ego between the sexual impulse, now in strong natural motion, and its goal, orgasm.

The position is like that of a man getting a thrill out of balancing on the edge of a cliff. He goes to the cliff because it is thrilling, and climbs over the edge. The nearer he gets to losing his balance the more thrilling it is; therefore, he is for ever venturing nearer the danger point, but when once his balance

is lost he tries desperately to stop the fall, to cling to the bank; and, naturally, fear has now taken the place of his previous excitement.

Unfortunately for this patient's desires, the inherited pattern of the sexual instinct is such that it will not be satisfied without its orgasm however long this is deferred. It must go to its logical conclusion sooner or later. He has placed his ego in its way, therefore it reaches its conclusion by overwhelming his ego, instead of with his ego surrendering to it and enjoying the experience.

As a result he (his ego) is overwhelmed or destroyed, but the strength of this ego position has not counted for nothing, it has succeeded in preventing a general orgastic experience. It has succeeded in retaining the nervous tensions which should have been discharged with the emission in the orgasm.

On the other hand his sexual instinct has also succeeded physiologically, though not psychologically. It has, in spite of his ego, had the emission, a reflex physiological action, leaving him and his ego behind retaining the undischarged nervous tension which should normally have accompanied the emission.

Thus he has, as it were, split nature's orgasm pattern into two parts, one a physical reflex of emission instigated by the instinct, and the other the accumulated nervous tensions heightened by his sexual excitements which he has prevented from accompanying the physical process and has retained within his nervous system unrelieved.

This tension is his anxiety state. It is as though the sexual instinct were for ever in motion and that he was for ever using all his ego control to prevent it from achieving its aim, orgasm.

Therefore, he feels as though he were always on guard. He feels also a great deal of anxiety, as though if he should at any moment relax his guard something that he will then not be able to control will break out. This is the psychopathology of his phobia that he will scream or do some impulsive act which will shock the community and occasion his incarceration.

He has brought about this state of affairs by a refusal to submit to nature's urges, while at the same time encouraging them for excitement's sake. As they do not obtain full satisfaction they are always with him, pressing to be satisfied. Their nervous tension is undischarged, is in fact prevented from adequate discharge through nervousness, causing his variety of anxiety

symptoms such as palpitation of the heart, rapid breathing, tremblings. If on the other hand he could relax and surrender himself to the natural lust within him, nature would merely fulfil its aim and enable him to rest until tension again physiologically arose.

My justification for classing as a symptom his over-concern about his appearance, physical and sartorial, is revealed in the following interesting dream:

"Again I dreamt that I was at the tailor's being fitted for a new suit. I had had it made of Royal Air Force blue and it passed through my mind that I was masquerading as if I were in the R.A.F. The tailor had a car which was finished in exactly the same material so that it all matched perfectly. I said to him, 'I will have that car'. The engine was no good, but I was only concerned with the appearance.

"Then my schoolboy friend arrived and on the dressing-table I had hair-brushes, clothes-brushes, cigarette-case and everything, all of the same blue colour. He passed some remark about their being a perfect match. Then I was in this beautiful-looking car, but had some difficulty in getting it started. Outwardly it was a good job, but it had a decrepit, rotten old engine and would not go. Then I dreamt that I was feeding at the breast but I cannot visualise any woman."

His associations are as follows:

"I am always dreaming of going to the tailor, whereas the place I am always coming to is here—to you for this treatment. I am dressing up like a peacock—all appearances—but not bothering about the real inward condition as long as I look all right and give a show of being a man. The 'engine all wrong' makes me think of my sexual function which is all wrong, feeble, won't work properly. I am like a broken-down penis—all dressed up, camouflaged, outwardly nothing wrong.

"I appear to be sound in every way, but it is only a veneer. The inside workings cannot be relied upon and they are not very powerful anyhow. All I am concerned with is concealing the fact, that is why I dress up like a peacock. I attract women and none of them knows that I am quite incapable of satisfying them anyhow. It seems to be some compensation for the fact.

"But I must admit the dream suggests that I am coming to you only in the hope that you will help me in this matter of

covering up my defects, not really of remedying them."

At this point I reminded the patient that throughout his analysis he had always emphasised the idea of *control*. It is by means of control that he persuades the outside world that he is really a man. His ever-present anxiety is lest he should lose control and reveal his deficiencies for all to see. If the beautiful fabric is taken off the car, they may see what a rotten old engine it has.

Some part of him has accepted the idea that it won't function, but he must not let anyone else see this. On the contrary, to compensate for the reality he must give the impression that it is a super-car, that is to say, that he is a superman, just because something in him knows that he is not a man at all.

This is a reflection upon the popular impression that the man who dresses too carefully is a "pansy", that is to say, lacking in sexual virility. This material suggests how correct the popular idea is.

The purpose of detailing this case history is to show the grounds for my conclusion that all this patient's anxiety, and, indeed, all anxiety and the phobias that accompany it, are nothing more or less than symbolical forms of the sufferer's genital sexual pattern.

Whether the dreams are about trains, buses or cars, or whether the patient's phobias are about trains, buses or cars, association of thought shows that these conscious concepts are nothing more or less than symbols demonstrating or dramatising exactly what takes place within the pattern of his sexual act. Like the clothes of this last dream, they at the same time hide from consciousness what the real worry or anxiety is about, or rather the real source of the worry and the anxiety.

This source is invariably the same, namely, something that goes on in the unconscious mind and is more nearly revealed by what goes on in the cycle of his sexual performance. Therefore it is waste of time to concentrate one's attention upon this camouflaged or symbolical representation of the anxiety. To do so would be simply to waste one's time with the shadows, leaving the substance untouched.

It is on this account that the patient's own efforts to understand and solve his anxiety problem have proved fruitless. We would be in no better position if we fell into the same trap. We may not have recognised this truth at first, but after studying

the patient's symptomatic and dream material session after session, day after day, it is at last borne home to us, in spite of all our initial resistances, that we are dealing merely with the reflection or shadow of his unconscious sexual pattern. Therefore it is our duty to leave the former and to concentrate upon the latter, otherwise our investigations will be as futile as those of the psychologist who concentrates attention upon the *manifest content* of a dream or symptom and ignores its *latent content* or meaning.

A conclusion so startling and so important cannot be arrived at without a superabundance of evidences and, as I have only just burst it upon the reader, I feel it would be more fair to his legitimate scepticism to offer the next little excerpt from this patient's analysis just to see whether or not it confirms this theory.

I feel it is particularly necessary to establish the truth of this theory as I propose immediately after to pass on to even deeper considerations.

From his association of thought to the following dream sequence it will be seen that the manifest content of these dreams (though in some cases connected with his phobias and symptoms) has in every case a latent content directly depicting his sexual and orgastic impulses and anxieties. He began the session by relating this sequence of dream items:

(a) "I was trying a car in a garage. That schoolboy friend of mine was there and I was trying to impress him that the car I had would go all right—that it was in working order and that his car was not.

(b) "Then I was standing outside a house and an aeroplane came over flying low. As it was near it started to swoop and turn upside-down, looping the loop. I thought it was sure to crash in a minute or hit the tops of the houses. I was frightened about it. All of a sudden there was a terrific crash and I thought, 'It is that aeroplane.' But it seemed it was something on the road that had crashed, and not the plane after all.

(c) "I was going to a Lodge meeting, but it seemed to clash with another meeting, a meeting of the Sports Club. I said, 'I seem to have made two appointments for the same date and time.'

(d) "Another time I was on a bus and it was going up a steep incline that was almost perpendicular. The bus got half-way up

and then started to run back. It ran back for quite a little way. Then the driver got it going again and went up this almost perpendicular wall. He got to the top and went very slowly over it. At last he had made the grade and had got up there all right."

The patient's free associations of thought to the dreams are:

"The schoolboy friend in the dream is the one that I told you about when we used to go bathing together and used to show ourselves to each other and compare our sexual virility, and here in the dream I am trying to impress on him that the 'car' I had would go all right and that his was not so good!"

"Regarding that bit about the plane. I remember when I was eight or nine watching an air-stunt display and the extraordinary feelings it gave me. I thought he was going to crash every minute. Now it seems to me that the plane in the dream had two cockpits one above the other—an extraordinary arrangement.

"My association of thought to that is exploring the anatomy of my girl cousin about the same age. Yes, the two cockpits, they are one above the other and the feelings were like those in the dream—a mixture of excitement and anxiety.

"It seems to me that the crash was when I got orgasm and thought it was finished for ever, only to find that it was not finished after all.

"The two appointments are my wife and the girl. The 'Lodge meeting' is the wife one and the 'Sports Club' is the girl's. They are in sports clothes and I see a lot of leg. I have got in a jam because I have got a wife and I want this other 'appointment'."

With regard to the bus dream he says: "A bus going backwards on a hill used to be one of my earliest phobias I was especially terrified when the driver changed gear. I always felt it was going to run backwards out of control.

"Now I remember that the other night in trying to satisfy my wife I suddenly felt that I was losing my potency and almost got in a panic. However, I somehow managed to get going and with considerable effort I managed to get to the top. I got there all right, but the orgasm was nothing more or less than an effortful 'only-just' accomplishment. It was exactly the same as this bus driver's effort in the dream."

At this point in preparing this case material I nearly said:

"We cannot avoid seeing that the patient's anxiety is contained within the cycle of his pattern of sexuality." But there I would be wrong. Of course we can avoid seeing it. We have only to shut our eyes! . . . and this in spite of the fact that every session will provide additional evidence.

The patient himself denies it, while at the same time for ever providing, however unwittingly, a further superabundance of evidence in support of it.

Nevertheless, we for our part must admit that even the slightest psychological phenomenon, such as a frivolous denial, is conditioned by unseen forces and must itself have some modicum of truth or at least causation.

The truth of this denial will be revealed in the next section on this subject. It lies in the fact that the patient is not essentially at a level of genital sexuality. He has not altogether reached that advanced stage of development. He is more fundamentally an infant in arms in the structure of his emotional reactions.

That we shall come to in due course. In the meantime it is enough to say that the denial of the sexual interpretations has that much truth to its credit.

However, it is material such as this repeated in a variety of forms that forces one, in spite of one's own resistances, to the conclusion that the state of anxiety means the state of details of the patient's sexual pattern—that all his symptoms and general conscious-level talking about his anxiety, phobias, etc., are merely, *like the manifest content of his dream*, a superficial substitution or displacement of the anxiety which has its nuclear source or origin within the pattern of his sexuality.

Therefore we are compelled finally to brush aside these appearances and to get down to a study of this nuclear sexual level of the anxiety, and to devote all our attention to it in our pursuit of a solution of the problem.

Having recognised this, it still remains to discover the source or origin of this pathological sexual pattern.

Presently it will be shown that the sexual pattern itself has been constructed out of various infantile impulses and inhibitions, desires and conflicts, that it is not a pattern which has suddenly sprung into being at adolescence—as it were from nowhere.

It will be shown that on the contrary every instinctual urge which the infant possessed at birth, and probably before birth,

and every impulse which it develops have a very real identity with subsequent genital sexuality, and that the vicissitudes of these urges lay the exact foundation for the subsequent vicissitudes of the adult sexual urge.

The infant at the breast is already experiencing an act of intimacy comparable to that of the adult in coitus. The differences are more apparent than real. Our shyness at witnessing the former phenomenon is a measure both of our intuitive recognition of its identity with coitus and of our repression of our sexual inclinations.

The only essential difference between the two acts is the locus of the organs through which they are experienced.

(3) The clinical material provided by the patient in his symptoms, his dreams and his free associations of thought reveals to us that its source lies in his infantile development. Unfortunately, the material leading to this conclusion is more diffuse and nebulous and therefore a little more difficult to interpret than the comparatively easy and direct revelations which take us down to its sexual nucleus and which we have so far considered.

Nevertheless, we cannot solve the whole problem of anxiety by contenting ourselves with an interpretation only so far as the genital-sexual level of libidinal development.

We must go further, to the infantile origins of this sexual pattern, if we are to understand anxiety. Psycho-analysis is no armchair theorising. We are entirely dependent upon the patient's own revelations for these discoveries. I will, therefore, quote the material of some more advanced sessions in order to make the conclusions drawn from them as clear and inevitable as those with which we have hitherto dealt.

On arrival at one session the patient said: "Today I am in a terrible state of tension and anxiety, full of tremblings, etc. I had to flog myself to come to the session today, I just felt I could not face up to things. I still find it difficult to carry on normally. It is a case of flogging myself all the time to do so. It is the same as the low state I got into when my anxiety started at the age of seventeen or so.

"I am whipping myself to keep going. I am not getting anywhere. The harder I try the more difficult things seem to become. I do not seem to have any confidence in myself. I am wanting somebody to take the responsibility for me.

"When I awake I think of the day and of the little things I have got to do and they all seem so insurmountable and difficult . . . and really there is nothing in them at all . . . an enormous effort for nothing at all.

"For instance, even coming along here . . . you probably notice I get a bit later every day. It is because I am at this pitch. Like everything else it is the *last* part of the journey here that I find most difficult. When I get as far as Jack Straw's Castle I suddenly get a sort of panic. I realise at that point that it is just as far to turn back and go home to my mother as it is to come on to you. It is the sort of boundary line. There I have to turn the corner. That point seems much further from home than the other side of it.

"Then on the way here I think, 'Supposing I am there first, supposing you are not there!' Then at the corner I see your car, and knowing you are there the tension and anxiety lighten. I think, 'Thank God I have not got the anxiety of waiting for another five or ten minutes!' I feel that I would never be able to do that. My feelings would become intolerable . . . perhaps I would dash for home again . . . or I would run from one place to another.

"Now I come to think of it, a lot of my dreaming happens just around about that part of Hampstead Heath."

When asked for his free association of thought to this, the patient replied:

"I can remember being there with that big boy from school. It was there we saw some people on horseback and he started a discussion about women riding horses. He said he could not see why people had any objection to them riding cross-saddle. He was looking at me through the corner of his eye while he spoke. This was before that week-end when he tried to get me to sleep in bed with him.

"I dreamt that I was driving in a car with two girls, one on each side, and it was at this place where you take the bend in the road. My association to that is moving from childhood into manhood—moving further away from mother's side, getting more to the stage when I have got to rely on myself."

ANALYST: "And you are not ready. You want to rush back to mother. What is the danger you feel you are running into when you leave her?"

"I feel it has got some connection with that conversation with that big boy. The women riding astride with their legs open.

In moving from mother I am as it were running into a pair of legs.

"I experienced some thrill during that discussion because I felt it was getting on to a sexual plane, discussing the legs of women because they were astride. It was being discussed by a boy that I was taught to look up to—not as a subject for sexual talk or discussion. He was using the incident purely as a motive for discussing something naughty, getting nearer to something dangerous . . . if not doing, at least thinking, something that was dangerous.

"I was ten or eleven years old at the time. Whenever I pass this place on the Heath, although it is now nearly twenty years ago, I seem to get panicky . . . my anxiety gets more acute . . . my stomach gets in a state of wobbles and there is general tension and excitement. It is something to do with the feeling that I am getting further away from mother and getting nearer to something dangerous . . . those open legs.

"I am thinking now of those two dreams I told you that happened on the same night. I could not get on with the car . . . something seemed to frighten me, and then I was dreaming that I was at the breast. I seemed to be hovering between the breast and something else which attracted but frightened. When I get frightened I want to run back to mother. I want her always to be there at my beck and call. I want somebody to comfort me."

When asked *how he would like to be comforted*, he said:

"Doing things for me, getting my meals, waiting on me, showing me affection."

ANALYST: "You must have been an affectionate child. Surely you wanted physical contact as well?"

"No doubt about that. I remember when I was about seven or eight years old a little boy of five came to stay with us and he was put in my bed to sleep. My first impulse was to cuddle him, which I promptly did. My mother told me to leave him alone, 'he doesn't want you to cuddle him'. I can still remember my feeling of acute disappointment when I was stopped from cuddling this little boy."

ANALYST: "You are still the little boy and you want to cuddle and to be cuddled, and it is because you are not getting it that you are in this state of acute depression."

"But now I resist being cuddled."

ANALYST: "You want to pretend to be a man. You are not being

honest with yourself; you are disguising your real feelings and pretending (remember that Air Force uniform dream). You are denying your real feelings—not getting what you really want and thereby increasing the strain instead of getting the relief."

"But there is something else that attracts me besides being cuddled, although it seems to increase my anxiety. And now I come to think of it this recent burst of anxiety began when that particular woman came to the restaurant.

"I had gone there and sat at that table in the hope that she would come. When she came I got very pleased and excited. She attracts me, but she is not at all accessible for flirting or for making advances to. Perhaps it was on that account that I tried very hard to impress her. I would be afraid to try with a woman who would fall for it.

"However, my efforts at last seemed to be becoming successful. She started to respond, or at least gave signs by her vivacity that I was making some impression. *It was then that I got into this state of anxiety.* I felt I might rush out of the restaurant any moment and what an awful show-down that would be. Then I thought if I did rush out I might scream in the street. I would be completely exposed and never be able to make a good impression again.

"I made a further appointment to meet her for lunch two days later, but at the last moment I panicked and did not turn up. It is since then particularly that I have been in this panicky condition."

In free association of thought to his idea that he was making an impression upon her, he says, "The phantasy which now comes to my mind is as though I were getting closer, more intimate with her. Somehow I am phantasying that she is opening her legs like those women on horseback, and instead of being pleased, as this seems to be what I was aiming at, I get in an awful panic with an impulse to rush away and scream. I want to run back home to mother.

"I think my trouble is that even as a child I was not satisfied with mother. I wanted to find out something more, something that was forbidden. That is how I got into trouble investigating the baby girl, and I am still doing similar things.

"It is some years now since I made a similar attempt with a girl I got to know one summer. That reminds me that when I was six or seven I was put to bed with an aunt of mine and

while she was asleep I tried to feel something. She stirred and nearly woke up and I got into a frightful panic.

"I am just the same now as I was then. I cannot help feeling my way into similar situations, but as soon as I find I am getting there I get in a panic and want to run away. When I am in a panic I want to get home to mother, or to get to you provided I can be sure you are here before me. But then I suppose I would only sally forth again and try to get into danger once more. It is just the same as when I was a little boy. If mother or you are not at home or I didn't know where you were, I would be in an awful state of anxiety."

This need for his mother or for me to be there at the appointed moment is later interpreted as his infantile need to have his breast-feed ready for him at the expected time. . . . The interpretation is that as a baby he used to get into a frantic state of anxiety unless he were promptly fed. The tension of increasing hunger would reach a point coinciding with his feeding time when it had immediately to be satisfied or it simply could not be tolerated. Screaming was not enough to discharge the intolerable tension which the breast-fed infant had accumulated and could not possibly endure.

If the analyst is there in time it is all right. Even five minutes' wait cannot be endured—he must dash off somewhere else, that is to say, look for another "breast" for immediate satisfaction. His infantile hunger-lust is the measure of his anxiety—an anxiety which must have been experienced sufficiently often to have left its mark upon his mental pattern for evermore. Moreover, this anxiety is subsequently felt whenever he has accumulated some emotional tension requiring immediate discharge and is failing to achieve its immediate discharge or tension-reduction.

At the same time the adults around him, particularly his parents, set him a high standard of endurance which he was not constitutionally able to tolerate. For instance, he was packed off to school at the absurdly early age of three years. In after life an aunt of his asked him whether he had been sent with a bottle under one arm and a napkin under the other.

He had not been, but he should have been! For he was being asked to control not only mouth and stomach tensions, but also bowel tensions at an age when such control was not natural or easy for him to accomplish. In short, already at the age of three

a strain was being imposed upon him to keep up appearances which he was not yet capable of maintaining with ease. He had to exert all his power of control, and this was not always successful.

He has not yet adequately remembered the enormous anxiety and distress which he experienced when his efforts to control himself failed, though he can remember that on occasions it did fail. The napkin should have been there. He had been breeched too soon.

Now this same demand for control which was beyond his power had dogged his life and was being experienced in the matter of his sexual tensions and impulses, still infantile or childish in their character.

At one of his sessions he brings me a dream which shows his anxiety and lack of confidence in connection with his as yet very immature sexual instinct. The dream is as follows:

"I was at a Sports Club and was going to the swimming bath which I fancied was somehow connected with the open sea. I changed into bathing trunks which curiously enough were pale pink in colour. By the time I was ready to swim the tank was empty, there was no water at all in it.

"What I noticed was the difference in depth between one part of the tank and another. The ends were shallow, but the centre of the bath seemed to go down to a terrific depth. That would be where the diving-board was. What impressed me was the consequent danger of this deep part. One end was very shallow—that would be where the children played. The other end was about six feet, but this middle portion was twenty feet or more.

"In the next part of the dream I seemed to come to a place that was like the open sea. The tide seemed to be very high. Though I felt I was capable of swimming across the stretch of sea, yet I felt that if at any part I knew I was out of my depth and there was a possibility of drowning, then I would panic and not be able to complete the swim. I do not think I started or attempted the swim, and yet there was a feeling that I could continue to swim up and down in the bath had there been no danger of drowning.

"At one point in the dream there seemed to be a very powerful fellow who shot through the water at a terrific speed. Then a girl came into the picture and I thought it would be nice to

flirt with her and to attempt some sexual play. As a result of this, the dream actually ended with an emission."

In association to this dream the patient says: "There was one part where I had got these shorts on. I had got my chest exposed and a girl remarked about the hair on my body with the assumption that I was a strong, powerful fellow. I did not disillusion her. I felt I was living in a make-believe world because instead of being a tough merchant I was exactly the opposite."

Regarding the swimming pool he says: "That very deep part was not the place for me as I could not swim unless I knew I might feel the bottom. It seemed to me that my end was the shallow end with the children, and yet I was making out, or swanking, that I was a tough merchant . . . acting a part, instead of being able to play the part . . . getting out of my depth . . . then there was danger always . . . that feeling of wanting to play safe, wanting to appear to be swimming—with one foot on the bottom . . . and yet I have a feeling of being spineless . . . no guts."

In association to the Sports Club he says: "There would be females there and near the swimming pool they would be almost naked. To me females mean, of course, their sexual characteristics."

Of the swimming bath he says: "Some restriction like marital relationship." And of the open sea: "No restriction, any and every woman."

In reference to his bathing trunks he says: "Nearer being nude—my body exposed. But", he says, "the trunks were pale pink—female, pansy . . . dressing for appearance like the material on the car. That was blue, this was pink. Perhaps the pink trunks should have had blue bows on them!"

"Now I come to think of it the blue car reminds me of my pram and there were blue bows also. The pink is like a cradle. Perhaps something in this dream is telling me I am babyish. A baby is all mouth and no sex organ. It wants the breast, not the other part of a woman."

About the different depths of the swimming bath he says: "Different levels which some people are capable of using or operating in. The deep part is dangerous to me, like the woman when I felt I was making an impression upon her. The next thing is she would be giving herself to me, she would expect

something sexual from me and I would be incapable of it.

"Like the bath it is all right to play with, but to get right in is dangerous. I would panic and run away—run to mother . . . and that reminds me of the dream where I had the nipple in my mouth. The shallow part of the bath is just play, sexual play, playing around instead of getting into it, because after all I am not a very powerful fellow really, not like that man who shot through the water at a terrific speed."

ANALYST: "Who was the powerful fellow?"

"Well, as a child I suppose I looked upon father as a powerful fellow, though he does not seem to have made much impression on my mind, I can hardly remember him. Mother, and since mother, women, seem to matter everything."

Psychopathology: It should be quite clear from even this short excerpt of this patient's clinical material that he is psychologically, or emotionally, still an infant in his degree of sexual development. He has never outgrown the forces or anxieties which he first experienced in his earliest days at the breast.

From then onwards it has been demanded of him that he should control rather than gratify his instinct urges, that he should for ever pretend that he was able to control when in truth he was still unable to do so and could at the best only put up a pretence which was every now and then unsuccessful.

He was put into breeches when he should still have been in napkins. He was sent out into the world when he should still have been in mother's arms. The standard of life set him was beyond his years. It entailed a strain, and he has ever since endeavoured to deal with life by strain and stress instead of by submitting to his natural development—or lack of development.

Thus his one idea is still appearances, to put up an appearance, instead of turning his attention to the reality of his emotional nature and its needs. This ego interference with nature instead of making him a man, has inhibited natural development, and kept the all-important nucleus of his being in its original infantile state.

Life demands of him control which is beyond his powers, or seems to be, for he is still emotionally an infant who unconsciously wants to get back to his mother's breast. In phantasy, as his dreams show us, he lives in cots and cradles dressed as a baby admired by the passers-by.

This admiration is his emotional consolation to replace the gratification of his instincts the denial of which had been set up as an ideal for him from a very early age. The attempt to control these emotions, whether they be oral (that is of hunger), anal (that is of a need to relieve his bowel tensions) or sexual (that is of a need to relieve the pressure of his sexual instinct), entails a constant vigilance of his ego control. He is always in a state of anxiety lest this effortful vigilance should for one moment relax and he should again suffer the pangs of unrelieved need for the breast, dirty his breeches, or fail to control his unrelieved sexual reflex. At the same time, the tensions of all these instincts, striving for relief and not achieving it, is diverted on to the other side of the conflict and leads to a constant stimulation and maintenance of his emotion of anxiety. Along this morbid path there is usually no possibility of complete relief.

But as we showed in one instance in the material given in section (1), even along this morbid path of anxiety he has learned to achieve something comparable to orgasmic relief. In that instance it caused a disappearance of his headache. So we see that this patient's bouts of anxiety and attacks of panic are in themselves a physiological substitute for the normal mechanism of relief by sexual orgasm.

In short, he has his anxiety state and the symptoms of it *in place of* a normal sexual life with its periodic and pleasurable discharge of tension.

It is beyond his conception to alter this condition to which he has become so thoroughly accustomed, practically from the time when he was a baby in arms. His revelations during analysis show that he is only using me as a detail within the scheme of his emotional and psychological needs. Instead of, as a baby, clamouring for his feed and demanding that mother or rather the breast should be there on time, he clamours for a regularity of his analytical sessions and demands that the analyst should be ready for him exactly on time.

Further, as his dream of the tailor's (part (2) of this chapter) especially reveals, he is not asking that the "engine" of the car should be put in proper working order, but merely that it should be clothed in a beautiful covering similar to that of his pram so that the passers-by may again give him their admiration. He is attempting only to substitute appearances as a compensation in place of the defective reality the alteration of which

has long since ceased to interest him.

In short, he has not grown up. He does not really want manhood or the rôle of a husband. Unconsciously all he wants is a perennial babyhood with plenty of breast regularly supplied, together with the admiration of all and sundry.

His anxiety is due largely to the fact that he is still straining and striving to give the appearance of achieving the impossible. It is fundamentally impossible for the baby to be a man, or even to be competent in consistently appearing to be a man. If he can be induced to realise and accept the nature of his emotional pattern, to recognise that his rôle is that of being comforted by a mother-figure, rather than that of achieving sexual conquests, a continuous strain will be relieved and comfort instead of anxiety will result.

As a result of the progress which he has already made in this direction he is now more content with an affectionate relationship with his wife and less insistent upon striving after repeated sexual activity which commonly neither he nor she really desires.

This new habit of life, together with a recognition that his anxieties and panics are not the dreadfully devastating phenomenon which he formerly supposed them to be, but are nothing more or less than the infantile anxieties associated with a failure to gratify his baby wishes, has already resulted in a considerable diminution of his anxiety and a complete disappearance of his tendency to panic.

A study of this case leads us to an interesting reflection which takes us from the realm of psychology into that of physiology. It has already been said that anxiety is the antithesis of sexuality. It is as though vital energy can flow in one of two opposite directions, or along one of two antithetical nervous paths.

The one is the pleasure-path of sexuality which leads to the expansion and multiplication of life, the other is the path of anxiety which leads to a withdrawal from the environment and a bottling-up of energy within the system.

This antithesis has its anatomical and its physiological counterpart. The autonomic nervous system, which lies for the greater part outside the central nervous system and consists of an immense number of ganglia containing nerve cells and a network of minute fibres which go to every organ and involuntary muscle

of the body, is a relatively primitive structure which has the immensely important function of regulating the viscera and, through the emotions, of conveying to them the special unconscious requirements of the moment.

Each viscus, large or small, and even the muscles of the minutest arteries and the glands of the skin, each receives antithetical pairs of fibres. One element in the pair comes from the part of the autonomic nervous system called the parasympathetic, and the other from its opposite number called the sympathetic. The former is chiefly concerned in functions which would include expansion and pleasure. The latter is chiefly concerned in responses to the emotions of anxiety.

An exceptional degree of sexual tension, conducted along the parasympathetic, would tend to discharge itself as orgasm, whereas an excessive degree of anxiety tension, conducted along the sympathetic system, would lead to a condition described in medicine as "sympatheticotonia" and would tend to discharge itself in some such phenomenon as an hysterical outburst.

We cannot here go into details of this interesting physiological antithesis, but the point for us in connection with the above-mentioned clinical material is that it seems from this patient's experience that an anxiety discharge can actually produce relief of tension comparable to that of an orgasmic discharge.

Perhaps this discovery is not so strange when we reflect that many a woman speaks of "a good cry" as a relief for her pent-up emotions.

A further consideration of these psychological and physiological phenomena would bring us to a formula for the production of orgasm on the one hand and for the symptoms of the anxiety state on the other.

Space will not permit me to dwell upon this subject at greater length, but I can say that in the particular case under consideration the development of the formula was traced to events which can be itemised as follows :

The first event: nervous tension (which may be conceived of as electricity), is produced by the bodily life-processes and accumulates within the system. This accumulation of tension received a very important reinforcement at the development of puberty.

The second event is that this tension presses for its relief and activates the phenomenon of masturbation, achieving thereby periodic reduction through orgasm.

The third event is that, on account of the development of ideas and ideals, psychological forces are mobilised to oppose this process. Finally they succeed. The masturbation stops but tension nevertheless continues to accumulate.

The fourth event is that control has to be further reinforced to keep in check the ever-mounting tension. The intra-psychic condition is now not only one of conflict but also one of pretty considerable suffering. Increasing tension frequently threatens to break through the controlling forces. Whenever it nearly succeeds the controlling ego experiences anxiety. The ego is afraid of being overwhelmed by the instinct-pressure in the unconscious.

The fifth event is that this feeling of anxiety itself carries off some of the accumulated tension so that the tension has now found an alternative path to pleasure or sexuality, namely the path of anxiety-stimulation.

The sixth event is that, evidently travelling along this newly established path of anxiety (sympatheticotonia), the tension now tends to overflow into various parts of the body and to discharge itself somatically by various anxiety symptoms such as palpitations and tremblings. At the same time the strain of the conflict, particularly by the efforts of control, leads to congestion which causes headache and to various muscular and other tensions experienced as strains and pains.

We now have a state of tension so great that in spite of all psychological control it is overflowing in every direction. Both the experience of tension itself and the experience of its various overflowings are distressing or intolerable.

The interesting position now is that the system has acquired a new path, other than that originally designed by nature for pleasure and propagation, for the discharge or reduction of accumulated tension. This new path is that of anxiety, the very antithesis of pleasure and of sexuality.

Nevertheless, along this anxiety path it seems, from some of the material gained from this patient, tensions can achieve some discharge. It is thus that an anxiety crisis can relieve this patient's headache very much in the same way as a pleasurable, satisfactory orgasm would normally do.

The question has arisen whether anxiety is a psychological or a physical (that is, physiological) phenomenon. It is the same question as to whether sexuality is a psychological or a physical (that is, physiological) phenomenon. The answer is the same in both cases. They are each psychological in their origin but physiological in their execution. What is more they each have a specific anatomical basis. In the case of sexuality it is the parasympathetic part of the autonomic nervous system, and in the case of anxiety it is the sympathetic part of the autonomic nervous system.

It appears that these two phenomena, sexuality and anxiety, are antithetical. Sexuality (without conflict) is accompanied by feelings of pleasure and well-being and results in an extension of life, whereas anxiety is accompanied by feelings of unpleasure, ill-health, and leads to a withdrawal from life.

Life can "expand" only when it feels safe, that is to say in the absence of danger or absence of the feelings of anxiety.

It is as though the life-current, tending naturally to expand outwards and to extend, increase and reproduce itself, is driven back when it senses danger. It withdraws into its own interior, closing up its contacts with the outer world and finding no expression except in the form of tensions, pains and commotions inside. Thus we see that this latter condition is synonymous with a lack of potency. It may not be too much to say that every sufferer from nervous trouble is the victim of some such functional inability to achieve full orgastic psychosexual potency.

It may be said that the criterion of complete cure, namely a restoration of full orgastic potency with entire freedom from anxiety, is an ambitious one in view of the fact that physiological and perhaps even anatomical paths have been laid down and established within the sufferer from perhaps a very early age.

But it can be said that in this instance the patient, notwithstanding his previous rejection on medical grounds for national service, subsequently volunteered and was accepted.

I have recently heard that he has been promoted to commissioned rank.

CHAPTER VIII

NERVOUS BREAKDOWN (ANXIETY HYSTERIA)

(1) *Introduction:* The term "nervous breakdown" is of course no more scientific than other classificatory categories of psychogenic illness. It might for instance be used to designate the irruption or early stages of almost any variety of mental or nervous disorder, in the same way as the term "neurasthenia" was for many years used by practitioners of medicine to cover a multitude of sins from anxiety neurosis to schizophrenia.

Nevertheless in its most general usage it usually indicates a condition, or a variety of conditions, between anxiety neurosis and hysteria proper. The term is here used for several reasons, but chiefly because this transition stage between anxiety and hysteria is not only very common but often far from transitory. The patient appears to oscillate between the acute mental discomforts of the former and the comparative mental tranquillity, the *belle indifférence*, of the established Conversion Hysteric. Moreover it may be said that almost all cases of anxiety state show a variable tendency to hysterical mechanisms, and almost all hysterias show fluctuating degrees of anxiety symptoms.

Therefore I have called the following case "nervous breakdown", for though it savours more of anxiety than of hysteria, it is an example of a very common condition intermediate between these two illnesses, demonstrating their close relationship, and serving to draw the reader from his acquaintanceship with the former to his introduction to the latter.

The psyche in its mental agony seems to attempt the conversion of its tensions into physical symptoms simulating hysteria, but never really succeeds in establishing them.

(2) A great deal of nonsense is talked and written about nervous breakdown, not only for popular consumption, but even, I regret to say, in standard medical works. For instance, the alleged causes are usually classified as follows: heredity, environment, worry of all kinds, overwork, fatigue, ill-health and (last and presumably least) sexual irregularities.

The subject is shrouded in mystery and obscurity, giving the impression that the authors lack the experience or the courage to extract the truth—or else they have not taken the trouble to investigate even one case in sufficient detail.

The case about to be recorded—typical of case after case which consults the psychotherapist—will not only reveal the characteristic aetiology (*causes*) of the condition but will give us some insight into the simple mechanisms of symptom-production.

But these deeper and more interesting considerations must be deferred until we have seen the patient and heard the alarming story she has to tell us.

For the sake of clarity the material of her interview has been rearranged to give the impression that she tells us all her symptoms first before she takes excursions into her case history.

They are all the characteristic symptoms of acute nervous breakdown—and her case is remarkable chiefly for the fact that she has almost the whole conglomeration of them instead of exhibiting, as most patients do, only a selected few.

(3) The patient, a healthy-looking, single woman of about thirty years of age, complains as follows:

"I was quite well until a few months ago, and then I began to get these horrible feelings. They have got worse since, so that I am now hardly ever free from them, and sometimes they get so terribly acute that I am convinced my last moment has come. But, apart from these horrible attacks, I can't say I am ever completely well. There is a constant feeling of general irritability, as though I were in a state of excitement all the time. It is most uncomfortable.

"And I can't bear the slightest noise. A clock ticking, even in the next room . . . nobody else can hear it, and yet I can hear and think of nothing else until it is removed. If a dog barks in the street outside I jump out of my skin.

"But even if there is no sudden noise and nothing happens, I am still expecting something of an unpleasant or terrible nature. I keep wondering what awful thing is going to happen next. If there is a knock at the door I feel it is the police, or some bad news. If I get a pain in my chest I think it is cancer. This has been my condition for weeks now—a state of tension and anxiety. I know it is silly, but what am I to do about it?

"But I have only told the mildest side of the picture. The

other side is so terrible I am almost afraid to think about it—only too glad to be free of it when it is absent, as at this moment."

ANALYST: "Tell me."

"I get the most indescribably terrifying attacks. It almost makes me shudder to think of them. I never know when the next one is coming. Although I have now survived several, every time they come I am convinced it is going to be my last moment. Anything and everything happens to me. I feel I shall scream if I start thinking about them now."

ANALYST: "*It will be all right. I think you had best describe them.*"

"Sometimes it is my heart. It jumps, or stops, or races away at a terrible speed. Sometimes I gasp for breath, or think I am going to choke. I break out in a sweat and start trembling and shuddering all over. Why it doesn't kill me, I don't know. I should mention that apart from these attacks, since this breakdown came I get frequent sweatings and tremblings without any cause, and all sorts of other attacks can happen to me, funny feelings that rush up to my head so that I think it is going to burst.

"Sometimes my knees are so sensitive that if anything touched them I should scream. Then my face will get all flushed, and hot feelings come over me, only to be followed by cold chills and shivering. I also get dreadful attacks of giddiness which make it impossible for me to venture out in the street in case one of them comes on. I should be quite helpless. Perhaps that is why I have been afraid to go out alone since this breakdown.

"Then sometimes I get attacks of acute indigestion and diarrhoea. It is difficult to believe as the doctor told me, that it is all nerves. I think I must have developed some terrible illness. That again puts me in a state of anxiety.

"I have to keep passing water every few minutes. No sooner do I sit down than I have to run off again. In fact, everything seems to have gone wrong. The miracle is that I am still alive after all that I have been through in the last few months.

"One thing I forgot to mention: rheumatic pains. But I left these out because I am sure that they are not part of the nervous breakdown. I think I must always have been subject to rheumatism, but nothing like I have been through during the last month or two. More often than not I seem to be aching all over.

"You have asked me to describe my symptoms, doctor, but it is quite beyond me to describe the terribleness of the acute

attacks. Sometimes when I do drop off to sleep through sheer exhaustion, I awake with a scream in the night, convinced that I am dying. In fact, I have thrown myself back on the bed, shouting that I am dead!

"When I went up to the hospital they asked me a lot of questions about whether my mother or father or other relations had suffered anything like this. Or had they had a mental breakdown?

"I suppose it means that this sort of illness can be inherited, but there is nothing of that sort in my family. I seem to be the only sufferer. Though perhaps I should mention that my father is rather a nervous man, and my mother is highly strung. I am the only child.

"When I was a girl of fifteen I got rather a bad shock, and that upset my nerves for a little while, but I soon got over it, and I don't think it has anything to do with the present trouble."

ANALYST: "*What was the shock?*"

"A man got hold of me on a dark foggy night, but I screamed and got away. Anyhow, it did upset my nerves for some days, and I got a feeling something like the one in my head. But I was soon quite well again.

"It did not frighten me too much. At seventeen I used to have quite a gay time with boys. A girl friend and I used to go out together. Of course, I never let them go any further than a little mild love-making, but I think I enjoyed all that very much, because those were the best years of my life. I dare say it was exciting, but there was nothing wrong in it.

"Perhaps I should tell you, doctor, that I have had a previous breakdown like this one before. It happened a few years ago. I had been engaged to a man for about five or six years, and we had become on very intimate terms. He came to live at our house, so I used to see him every day, and we would sit up after the others had gone to bed and make love together. But I stuck to my high principles, and so I never let him go too far, though you can quite understand that, knowing him all that time, perhaps we went a little further than we should have.

"Now I come to think of it, I had a few nervous ups and downs towards the end of that long engagement, after he had been staying at our house for some time. Perhaps it was the nervous strain of the whole situation, because it was not very satisfactory.

"I dare say I would have liked to have gone further with him, but it was becoming clearer, especially to my parents, that he was no good for marriage. He kept on being out of work, and unable to pay his share, so that they had to keep him at home for nothing.

"Finally they told me he was no good, and turned him out. I was not allowed to see him again. That was when I got my first breakdown. It was bad enough, but not so bad as this one. I gradually got better after six months or so. But I don't think I had entirely got over it all when my present fiancé came into my life.

"That was only towards the end of last year. We soon became very fond of each other. We made love together four or five times a week. And at first I thoroughly enjoyed it, and my nerves got perfectly well. Of course, I drew the line at sexual intercourse, as I am determined to have none of that before marriage, though I must confess that at times the temptation was very strong.

"Then it seemed that quite suddenly all my feelings changed. One night I felt I could not bear him to come. I could not bear the sight of him, and when he was in the room alone with me I felt I could scream. I did scream at him once. He thought I had gone mad. Whatever am I to do about it all? At the thought of him now I scream, or as likely as not go into one of those terrible attacks.

"For no reason whatever I seem to have turned against him. I get nervous feelings when I see him and tremble all over. No wonder I get fits of depression as well. The doctor advised me to marry him at once, but the thought of doing so now makes me feel I'd die of it.

"I suppose I think it would be all that kissing and cuddling over again. Really I could not bear it, I'd scream or burst or go mad.

"My head often seems to swell up and feels as if it is going to burst."

Without apparently realising that she was giving free association of thought, she continued:

"This morning I felt terribly sexual for the first time since my breakdown. I could not settle down to anything. I tried to read my book, but couldn't take it in. I thought I should like my young man to come and see me, though I dare say if he really came it would all go and I'd get these terrible feelings instead and want to scream. It has happened like that before.

"I told you of that pricking and stinging feelings in my legs. Well, now I feel awfully irritable, and I have got it in my arms too. It frightens me. I feel I am going to crumple up any moment. If I get one of those terrible attacks again I am sure I shall die.

"It seems I either get like this or else I am terribly unhappy and depressed, and then it seems that everything is dead . . . dead . . . *dead!* And then I get the feeling of boredom. That is what I feel marriage would be like."

ANALYST: "*What went dead?*"

"Sex went dead. I don't know why it went dead. All I know is that I suddenly got these feelings of depression and felt dead. Then I began to think of it all as something unpleasant. Oh, yes! I should have mentioned that there was a time after the pricking and stinging feelings in my legs had been particularly bad, that my legs really did go dead. I couldn't feel anything in them; I couldn't feel them when they were touched and I began to drag them when I tried to walk. It's a pity they did not stay like that, but if they had done I fancy I should have lost the use of them altogether." (This indicates the tendency to hysterical conversion)

"But that seems something quite apart from the terrible feelings which I can't control, and which I fear will get the better of me one of these days, and be the end of everything.

"I'd rather feel the depression than those awful frights. Do you think, doctor, I had my breakdown so as to get rid of my sexual feelings?"

ANALYST: "*Were you finding them so intolerable?*"

(4) *Anxiety Neurosis*: Freud extracted from a conglomeration of symptoms labelled by various practitioners "neurasthenia" and "psychasthenia", a distinction between what he called the "actual neuroses" and the "psychoneuroses".

The former he showed to be due to specific physical factors in the current sexual life, and the latter to be due to psychic factors, often no longer current but due to infantile emotional experiences.

He distinguished within the compass of the "actual neuroses" a specific entity which he called "*anxiety neurosis*". The characteristic mechanism of this, according to him, was that stimuli originating in accumulated sexual tension failed to enter consciousness as a sexual urge and were in consequence deflected into other paths, manifesting themselves as a variety of symptoms physical and psychical.

He drew an antithesis between this neurosis and neurasthenia, anxiety neurosis being due to an *accumulation* of excitation, and neurasthenia to an *impoverishment* of it. Nevertheless, he pointed out that in the same patient the two diseases could exist in rapid alternation or practically side by side.

Although this work is fifty years old, attention is being called to it because the lessons Freud taught have not yet been learned by the public nor by the majority of practitioners. The difficulty lies in the fact that neurosis is seldom or never pure. It is practically always mixed up with symptoms belonging to another or related neurosis and to more than one psycho-neurosis, but although each case presents a mixture both of symptoms and of diagnosis, yet there is some reason for making distinctions because the causes of one diagnostic group of symptoms differ from the causes of another group.

Freud's list of the symptoms of what he called anxiety neurosis may with advantage be compared with the symptoms related by the patient whose case is here described. His list:

1. Loss of .

5. Awakening in fright.
6. Difficulty in locomotion usually due to attacks of vertigo and commonly leading to agoraphobia, or fear of open spaces.
7. Disturbances of digestion and sometimes undue frequency in urination.
8. Pseudo-rheumatic pains.

It will be noticed that our patient fulfilled practically every one of these qualifications to justify the diagnosis of anxiety neurosis. Hers would be almost as pure a case of this trouble as could be found were it not for the tendency to proceed to a more advanced stage in the *morbid process*, indicated by the transitory anaesthesia of her legs and impaired locomotion (*conversion hysteria*).

There are just one or two symptoms which are those of anxiety hysteria though not so many as one usually finds in a case of nervous breakdown.

One such symptom was a feeling of something trickling down her leg, which by association of thought was shown to be related to a psychic trauma that had occurred at her first menstruation. This, however, would come under the category of a symptom of a psychoneurosis (*viz. hysteria*).

Actual neuroses in contradistinction to psychoneuroses are not produced or maintained by any single psychic shock, but on the contrary are kept up by current accumulations of nervous sexual tension. Their cause is in a sense physical rather than mental, and they cannot be cured by psychotherapy alone unless this leads to some correction of the incorrect current habits.

Psychoneuroses, on the contrary, whatever symptoms they portray, have their cause or origin in psychic material, such as sexual shocks and emotional stresses of early life including infancy.

They will not be cured unless, by an analytical process, the current symptoms are traced back and, through the patient's free association of thought, linked with their earliest origins.

The same applies to obsessional neurosis which, like hysteria, is a psychoneurosis.

Now my reason for calling the present case history "nervous breakdown" is that, whatever particular neurosis or psychoneurosis the patient may be suffering from, the *breakdown* or sudden outcrop of acute nervous symptoms is most frequently

connected with at least some proportion of anxiety neurosis. More often than not this is, as it were, the spearhead of the illness.

The patient may have been a potential hysterical or a potential obsessional neurotic, or a potential neurasthenic, but she has carried on more or less successfully with her work, until an accumulation of undischarged sexual tension was precipitated by some factor, sexual or non-sexual, physical or mental.

In consequence of this accumulation of undischarged sexual tension the immediate breakdown which ensues has several of the characteristics of anxiety neurosis. Of course, the immediate precipitating cause may not be the real source of the anxiety neurosis symptoms.

This source is always accumulated undischarged sexual tension which has been deflected from the mental path; that is to say, *the patient, instead of being conscious of sexual urges, becomes conscious instead of all sorts of alarming feelings and symptoms.*

Behind this sort of beginning to a breakdown proper, the picture may be confused by a large number of symptoms which, strictly speaking, do not belong to the anxiety-neurosis group but to latent hysteria or obsessional neurosis, or other mental or nervous potentialities within the patient. These are perhaps being more or less suppressed until the acute outbreak of anxiety neurosis carries them into the stream of symptom-formation.

Perhaps this account will help the reader better to understand why there is so much confusion regarding varieties of nervous illnesses, and particularly why there is so much nonsense talked about their causes.

If a house falls down when a heavy lorry passes in the street outside, it may then not seem too easy to come to a conclusion as to what were the causes of its collapse—whether it was water or fire or what not that had eaten into the structure, or whether it had been badly constructed from the start. It would obviously be incorrect to regard the lorry as being the sole cause of the trouble.

It is extraordinary how innocent or ignorant the conscious mind can be of the source of the stresses and distresses which exist or are being provoked in the deeper and more primitive levels of the psyche. People can put burdens upon their primitive nature, upon their instinctive desires, and be quite unaware

of the weight they are voluntarily bearing.

When this burden becomes intolerable, breakdown ensues, but they still remain quite ignorant of its source and causes. What is perhaps even more surprising is that the doctors they consult are often equally mystified.

The facts are that in the aetiology of nervous breakdown, apart from heredity, we find the burden to be upon the functions of the sexual instincts, suffering under repression, and therefore sometimes quite unconscious. Increasing tensions are thus set up which may at any moment break through the repressing forces and manifest themselves in the form of one or more of the symptoms of nervous breakdown, with or without the attendant psychical symptom of morbid anxiety.

Thus the adolescent who is all but ripe for sexual life, upon meeting with her first introduction to sexuality, commonly manifests some of the symptoms of anxiety neurosis, but here the picture is sometimes confused with hysterical conversion symptoms.

A fair number of cases occur as a result of sexual abstinence. This appears to happen more frequently in males.

A young man recently consulted me because his work had become a nightmare on account of the puzzling anxiety lest one of the staff should come up and put a question to him. It transpired that it was only members of the opposite sex whose questions would prove so disconcerting. The anxiety was almost incapacitating.

This young man was trying to live as though sexuality just did not exist. His glands, including those of his skin and, to his discomfort, neck and face, gave the lie to his conscious pretensions. Continence and health are evidently not possible to *all* human beings. Maybe otherwise there would be no human beings!

The victims of long engagements provide a large proportion of the cases of nervous breakdown. The aetiology here is clearly that of frustrated instincts. A contributing factor is that conflict in connection with the sexual impulse makes it appear bad, until finally the feelings experienced are very bad indeed.

The case history here given in detail is a typical instance of these factors at work.

A psychologist sees an even larger number of cases with the

identical symptoms among married people of both sexes, who to avoid pregnancy or for some other reason are practising some abnormal interruption of natural sexuality.

Single people suffering from nervous breakdown are apt to point to such instances in the case of their married friends, and to declare that their illness cannot be due to sex, as "So-and-so", who is married, has similar nervous troubles.

Within marriage and within the sexual act itself there is room for every aetiological factor of nervous breakdown.

The husband who practises *coitus reservatus* to satisfy his wife's sexual needs, puts on himself the strain of reservation of his orgasm and is thereby liable to get a nervous breakdown, though in this case the symptoms of anxiety as described at the beginning of this chapter are likely to be accompanied by some of the symptoms of neurasthenia or nervous exhaustion.

He who practises *coitus interruptus*, obtaining his own satisfaction and ignoring the sexual needs of his wife, is laying the foundations for her nervous breakdown.

That this breakdown may never actually occur is no disproof of the sexual aetiology. It is just a question of how great a burden she can tolerate. The fact that such breakdown when at last it comes may happen immediately after a period of over-work, debilitating physical illness or mental shock, merely shows that the last straw may break the camel's back—though with greater knowledge we must recognise that it was really the load that the back was bearing before the last straw was placed upon it.

Further proof of the sexual aetiology will be brought forward when we later discuss the psychopathology of nervous breakdown, where it will be shown that the symptoms all arise directly from the tensions produced by unrelieved sexual tension.

Other factors in the causation of nervous breakdown include the excitement of the climacteric period in both sexes, where there is a temporary increase of sexual tension with less internal and external facilities for its discharge.

The factors of overwork and illness, so often referred to in orthodox aetiologies, can be safely regarded as merely contributory factors acting upon a nervous system already overloaded with undischarged sexual tensions.

This is the usual state of affairs in such persons as some

masturbators who have by excessive practice made themselves incapable of tolerating even a normal degree of sexual tension. Therefore their breakdown is more likely to occur when, by a Herculean effort of will, they have succeeded in temporarily giving up the practice.

(5) *Psychopathology*: The explanation of the situation is that sexuality is not a unity, but consists of two contrasting and opposite parts. It is the failure to recognise this essential fact about sexuality which is responsible for all the confusion and apparent contradiction in connection with it and its functions in the promotion of health and illness.

It is sometimes said in depreciation of Havelock Ellis that he spent his lifetime and covered seven volumes in describing the world in terms of what he called "Tumescence" and "Detumescence". If the lesson he has to teach is rightly understood his life was not wasted, nor were the seven volumes too much for such an important lesson.

These are the two parts of the sexual act. Tumescence may be defined as a heightening of sexual tension and all that contributes to such heightening. Detumescence is the reduction of that tension.

Psychologically it does not matter that the first part of the sexual act can occupy an immeasurably greater time than the second part. They are complementary to each other, and if tumescence does not lead to its natural sequel, detumescence, the same sort of result may be expected as if the pressure within a boiler steadily increases without any reduction of pressure being permitted.

Should we be surprised if an explosion is the consequence? Nor perhaps should we be surprised at what direction the blast may take. Small wonder also that the ego, sitting on top of such a boiler, should feel some cause for anxiety.

Briefly, then, the source of anxiety neurosis is an accumulation of undischarged sexual tension. The accumulation is primarily the inevitable result of the life processes themselves. The failure to achieve discharge is due to forces within and without the psyche.

The former are more important and include conscious and unconscious opposition operating so that the sexual tension is prevented from reaching consciousness as a sexual urge. In fact the opposition may be so overwhelming that the reaction to

sexual stimuli may be comparable to that of a thirsty victim of hydrophobia to water.

So much for the source of anxiety neurosis. There may be two principal factors responsible for the *form* the symptoms take. The first is fear on the part of the ego lest its control be swept aside by the enormous accumulation of tension below it. It reacts to the internal danger situation with morbid anxiety much as it normally reacts to external danger situations with normal fear.

The other mechanism responsible for symptom-formations is the diversion of the accumulated sexual tension into other paths. This is what I referred to as the direction the blast of the exploding boiler may take. Probably both mechanisms are at work simultaneously and reinforce each other.

For instance, the anxiety arising in the ego may cause the normal fear reaction of increased rapidity and force of the heart, and at the same time the accumulated tension may find this heart-muscle activity a convenient one whereby to discharge some of its dammed-up energy—just as a frightened rabbit can get rid of some of its anxiety tension by the muscular activity of running, or, if it cannot run, by trembling . . . and our anxiety-ridden patients tremble or shiver quite a lot.

Now the remedy for this morbid state of affairs may not prove so simple as the exposition of its mechanisms might lead us to suppose. This fact is linked up with the problem of why the patients concerned ever come to suffer in this way. The explanation will be found to lie in their particular psychological make-up and that of the society in which they live.

It is usual for the individual under the compulsion of his sexual impulse to find some more or less satisfactory outlet for it, at least when its tension becomes too strong to hold, in spite of the frustrating influence of his environment.

But there are individuals who in their youth have perhaps too whole-heartedly accepted the prohibiting attitude of their parental and other mentors, and perhaps too successfully adopted it as their own. The burden of being such good members of society may be too great for their nervous system to carry without some unwelcome bursting-out of tension in the form of symptoms subversive of their ego control.

Also there are individuals who, while permitting pleasurable stimulation and accumulation of tension, seem determined at all costs to prevent its reduction. Thus, if they indulge in sexual

intercourse, and even if they enjoy it, they will rarely permit orgasm to take place. In consequence they accumulate the nervous tensions which may sooner or later break out in the form of the symptoms of anxiety neurosis. Frequently the fear of unwanted pregnancy is held to be responsible, and it certainly may be a contributory factor.

Some have even gone so far as to have unconsciously identified detumescence with death. This is the psychological explanation of our patient's symptoms of awakening in the night shouting that she is dying or dead. With the relaxation of sleep, nature tended to run its course and to reduce accumulated sexual tension by a dream orgasm. Her anxiety wakened her in time to stop this "calamity".

Finally, such a patient may be afraid to go to sleep at all, because in sleep she can no longer be on guard against her nature taking its health-giving course which she so morbidly fears.

Similarly, psychological motives may frequently be responsible for the very opposite form of conduct. Over-indulgence in sexuality such as over-frequent masturbation may, like sexual obsession, be an attempt on the part of an individual to reassure himself against unconscious "castration" feelings, themselves commonly resulting from an undue impoverishment of sexual tension. Hence the "remedy" naturally worsens the disease.

These few instances may bring home to the reader that, even in the simplest case of anxiety neurosis or nervous breakdown, however clearly due to physical factors, psychological factors lie behind the behaviour directly or indirectly responsible.

In so far as these are mostly unconscious, some psycho-therapeutic treatment is necessary before alteration and improvement can be effected.

(6) *The Problem of Anxiety:* It may be suggested that in discussing the problem of anxiety I have omitted the most obvious aetiological factors, in that I have failed to stress, or perhaps even to mention, such conscious sources of anxiety as ordinary war traumata.

My clinical experience, however, permits me to insist shamelessly that the omission is more apparent than real, for such factors prove on deep analysis to have no further aetiological interest than that of precipitating agents. The morbid (or

unreality) quality in the anxiety state provoked, coming months or years afterwards, can invariably be shown to be due to the activation, not of the conscious fear of death, but of the unconscious phantasy of castration with its source in Oedipus wishes, the only "death" with which the deeper unconscious levels of the mind are familiar.

I have dealt with this subject at some length in "The Analysis of a War Neurosis",¹ and some little evidence for the same conclusion may be detected in Chapter XXXI of the present book: "A Case showing Some Implications of Short Treatment". The conclusion is that a detailed consideration of traumatic precipitating factors offers little contribution to the aetiological study of the problem of anxiety, though they stand in the forefront of the analytical material and must emerge fully into consciousness before the deeper psychological conflicts, the real and predisposing causes of the condition, can be approached.

These deeper psychological conflicts have the effect, first, of arresting the normal psychophysical mechanism of tension-reduction, namely periodic orgastic relief and its displaced equivalents, and secondly, of contributing psychological elements to the resulting discharge of the accumulated tensions when they erupt in symptom-formations.

¹ *War in the Mind*, 2nd Ed. chap. xxiii, pp. 188-221.

SECTION III
THE HYSTERIAS

INTRODUCTORY

ANXIETY, though usually the primary and certainly the simplest of the manifestations of psychogenic disorder, is probably the most uncomfortable, and the most difficult to tolerate when very acute or protracted. An early stage of this intolerance may be detected in the accompanying physical disturbances whose range seems limitless, from palpitation of the heart and digestive disturbances to paraesthesiae and paralyses. In fact every organ and function of the body may be affected. It is clear that the tension of the anxiety state usually becomes so great that it cannot all be absorbed mentally in the subjective experience of anxiety and that the surplus overflows into somatic innervations.

What is more, instances are encountered where the common path of tension discharge towards the conscious mind, manifesting itself in the form of the mental experience of anxiety, seems to be more or less inhibited or blocked, and the patient may present himself with even a single physical symptom, such for instance as palpitation of the heart or gastric disturbance, without any consciousness of tension or anxiety.

Frequently also we meet with persons who seem to have a special facility for inhibiting their tensions from reaching conscious form and for deflecting them into somatic mechanisms of discharge. They are possibly persons who have from an early age experienced so much emotion that they have been forced, as it were, to develop an inherited predisposition almost in self-defence, in order to preserve some semblance of mental equilibrium.

These are the hysterics. Their close relationship to the anxiety neurotics, and indeed the merging of the one into the other, have been indicated in earlier chapters and this close relationship is perhaps clarified by the foregoing description of the transmutations of tension into anxiety on the one hand and into bodily innervations on the other.

As would be expected, we find in the aetiology of hysteria an unusual abundance of infantile traumata indicative of an overloaded early emotional life. A great facility for defensive

repression has thereby been developed, and, while transmutations of tension into conscious anxiety are inhibited, the path is laid open for their somatic absorption. But this process though typical of hysteria, particularly of conversion hysteria, is not the only mental mechanism at work. Perhaps the more essential element distinguishing, or forming a transition between, these cases and anxiety neurosis is the relative strength of the repressing forces and the consequent deeper level and greater violence of the unconscious conflict.

There is one further characteristic of the deeper psychopathology of hysteria which must be stressed, a characteristic which distinguishes it not from anxiety states but from the more severe illnesses to be described in the next Section, and that is that its nuclear source lies in a fully developed libidinal organisation at the genital level with capacity for whole-object love, in short in the Oedipus Complex proper. The constructions from pre-Oedipus levels of organisation (component instincts) are, as compared with obsessional and more severe neuroses and with psychoses, relatively few and uncharacteristic.

Before proceeding to the more typical cases of hysteria to be described in this Section I will give as an intermediary a case of a less established nature. The patient has many attributes of normality, including a tendency to suppress, or even repress, his sexual life, a strong compulsion to overwork as a defensive measure against the outcrop of an overloaded sexual instinct and as an alternative outlet for its tensions, and perhaps something of the cyclothymic temperament though apparently within normal limits. Hysteria when it came was in his case not an isolated bodily innervation but a total, though temporary, "knock-out" of his resisting consciousness.

CHAPTER IX

OVERWORK AND HYSTERICAL BREAKDOWN

In a little house, twenty miles from London, a virile young man of thirty suddenly broke down and started to sob and cry, to the bewilderment and alarm of his hostesses.

Nothing like this had happened to him before. He was inconsolable. He collapsed upon the floor still sobbing and threw himself about almost as if in a fit.

This continued for the best part of an hour. Suddenly he pulled himself together and insisted, in spite of protest, on dictating a letter—a very long letter.

The reason for this extraordinary sequel to his hysterical fit was that he knew he would not be able to continue with the business he had in hand and that it must be passed over to another manager, and he anticipated that unless he did it at once while his mind was "crystal clear" he might never succeed and the business would suffer in consequence.

His dictation was interspersed with minor bouts of crying, but, nevertheless, he overruled his hostesses' objections and stuck to it—till 3 A.M.

This most striking precipitation of a nervous breakdown was attributed to overwork. There was no disputing the overwork. This young man had, since the outbreak of war, been continuously engaged upon one Government contract after another, each with a short time-limit requiring incredible things to be done in an incredibly short space of time.

On every occasion he had been almost superhumanly successful. At what cost to himself his dramatic breakdown seemed to testify.

He was a most estimable and valuable person, and his associates had indicated to his doctor that they would go to any length to secure his adequate treatment and speedy restoration to health.

When I went into my waiting-room to collect him he almost overwhelmed me with the suddenness and forcefulness of his

greeting. He leapt out of his chair, seized me by the hand, and as soon as I indicated the direction of the room for the consultation he brushed past me and rushed to it. It was as though his vitality must be immediately expended.

I noticed, however, that his walk was more jerky than need be, and that he swayed from side to side, something like a highly trained prizefighter sparring in the ring.

It seemed to me that it would have suited him better if I had directed him to run around the room in circles rather than to sit on the settee and try to relax. Nevertheless, the method of relieving tension by muscular activity instead of by mental work is anything but psychological.

However, having persuaded him to immobility, the abundant rush of words and description which poured from him displayed, like his physical tendencies, an unusual amount of tension pressing for release.

He said: "I must get back to work at once, doctor. I cannot bear this inactivity. I am in the habit of rising at 6 A.M. and by 7 I am always hard at it."

"I had a Government contract to build six factories in three months, and I got it done, all but one, and that was only two weeks late. On occasions I had to whip all round England for the necessary materials, but I got them. I keep my contracts.

"With me work has always come first, that is why I cannot understand this absurd breakdown and the inactivity which you doctors are forcing upon me."

It will be appreciated that I had some difficulty in persuading this young man first to describe to me the attack and subsequently to tell me the psychological situation which precipitated it.

Finally he said: "Well, I just don't know what happened. All I know is that I could not see, my legs gave way, and they tell me I started sobbing and crying. I know I fell down. I expect I must have been over-tired. I had had no break for a long time.

"I had been at a directors' meeting all the afternoon and had done a lot of talking, laying down the law, I suppose.

"It was a Friday and I had been able to take the week-end off. I was going to a country hotel, and on the way I was going to drop the directors' secretary at her home twenty miles out of London. I have known her for some time, and she is engaged

to a friend of mine. We had dinner together; it got late and I was driving in the blackout. She was talking.

"At odd moments I kept losing the trend of what she was saying and at other moments I seemed not to be able to see the road very well. No, I had had nothing to drink; I never touch a drop of alcohol. I knew I was tired before we started and I had six cups of black coffee. At last we got to her home and she persuaded me to let her mother give me some refreshment before I proceeded.

"That is when the attack occurred. I was practically carried to bed afterwards and slept solidly for eighteen hours. That was nearly a week ago and I think I should now return to work. They say I must have your advice first, as I sway about when I walk."

It took considerably more time to persuade this impatient man to tell me his thoughts and feelings preceding the attack. At first he insisted that his thoughts had all been about business.

Finally he admitted that there had been something other than business that preoccupied his mind. "But, doctor, for months I had succeeded in pushing that out of my thoughts. There were contracts which I had to get on with."

This something turned out to be merely an affair of the heart—the minor contract of matrimony!

"I have known the lady for two years, and for twelve months we have been engaged. Of course, throughout all this time I have not seen her very often as the exigencies of work in wartime prevented frequent or very long meetings. Nevertheless, during the last six months I have been a bit worried, though I have been trying to brush it aside. It has been forced upon my notice that she and I do not see eye to eye. She is a bit of a snob, while I have no time for that sort of attitude to life. I am dealing with working men and my sympathy is with them.

"I have to get jobs done, and have no leisure or taste for foolish social gatherings. She does nothing very useful in life, and apparently despises those who do. I was thinking of this actually on that journey out of London, comparing my fiancée to the directors' secretary sitting beside me, and suddenly I felt infuriated.

"Instead of love, a feeling of hate surged up in me towards the girl I was proposing to marry. I thought, 'To hell with dilettantes'

and rubbish! Work has got to be done, the war has got to be won and all useless dead wood must be cut away.'

"Then, or just before that, I could not see the road. How we got to the house, God only knows. But what has all this to do with the absurd breakdown that followed? I did not tell the doctor anything about this, but I did tell him that I had been forgoing my customary sporting activities. Before the war I used to play hard at least once a week, but now the time has been given to extra work. Perhaps in consequence I am not so fit physically."

The story of this man's life is as characteristic as the impression of himself which he has given us. The son of a fish salesman, he had started life in the East End, working in his father's shop in the early mornings before going to school.

At fifteen his father went bankrupt. He obtained employment with a large fisheries where he soon found a job both for his father and for other members of his family. He worked arduously and knew he was entitled to the substantial rise which he presently demanded. It was not forthcoming. However, he had saved a little money, and with it he purchased a barrow and the goodwill of a peddling fish salesman.

The barrow had never before been put to such strenuous use. Within a few months the turnover had trebled itself. Within a few more he had more business than he could cope with single-handed. He employed his father and the other relatives from the fisheries.

Customers increased a hundred-fold. Horses and carts had to be utilised for the business. Presently he found that his profits were being largely swallowed up by stables and such like; he therefore decided to build his own stables.

The planning and construction were an advance upon existing premises and no sooner were the buildings completed than purchasers appeared wishing to take them over. He sold them at considerable profit. It then occurred to him that the profits to be had from such new ventures were greater and more rapid than those to be had from the retailing of fish. From stables he proceeded to garages.

His business acumen, fervour and keenness for work soon made him master of these new enterprises. Eventually he amalgamated and became a manager under a larger combine. Work was the guiding principle of his life. He was at it before

dawn each morning and it did not cease until he found himself at night, overwhelmed with fatigue, sinking into his deep and contented sleep.

What went on during that sleep is a matter of special interest for the psychologist.

Before analysis he not only had no insight into it, but no inkling that anything whatever did go on.

Presently he brings me a dream. He says: "*I dreamt I was boxing with a great giant. I was trying to beat him with speed. I realised that if I continued at that rate I would get tired out and then I would be at his mercy. Finally I fell down.*"

In association of thought to the question, "Why were you fighting him?" he says: "I was afraid. He was an evil-looking thing and I was afraid he might get the better of me. But having started to fight him, I dared not stop."

In association to "speed", he says: "The speed at which I work. It seems I dare not stop for a minute."

The "fall down" he easily associated to his collapse during the hysterical fit which precipitated his nervous breakdown.

Lying on the analytical settee, he presently agreed to stop fighting—to stop talking and to relax for a few moments. He starts up suddenly and says: "I think I must give up this treatment. I had a most horrible phantasy just now. I sort of dreamt that I was going down a dark pit, like a well, and it was inhabited by hideous forms, little creatures with horns on. I feel quite funny after that experience. I must be going crazy. Anyhow, in the dream I felt I must scramble out at once, that is all."

I tried to persuade the patient to let the phantasy continue. He interrupted me—"My mind is saying 'Let the Doctor talk', but I am not going back there."

Presently he says: "It was a round well that went down and down and down. All these hideous creatures with horns at the sides of it and hell fires below . . . these creatures are pressing against the screen I have put over it. They cannot stand daylight.

"My eyes looking down the well get accustomed to the inky darkness. I am coming out. No, go down. I am a bit frightened of what there may be right down. The little creatures are trying to close the barrier themselves.

"My mind seems like a well at present going down and down

. . . darker . . . going down a volcano . . . going down to the bowels of the earth. It occurs to me that if I could not get control I would become a lunatic and go to an asylum.

"At the bottom of the well there is a raging fire . . . and Satan the devourer. As you go down the flames get less and less. The little creatures seem to be saying 'We are not dead yet'."

ANALYST: "What are these little creatures?"

"Ah, they are spermatozoa wanting to get out. Once I let the lower levels have free rein they would boil over and the conscious mind would never be able to get control again. So far my subconscious has had very little outlet. I think of the small boy who put too much yeast in the dough. It rose and rose and he could not control it."

When asked for free association of this thought he said: "The rising up of sex. The boy is in the room and the dough rises and obliterates the boy."

ANALYST: "Is that like your giant in the dream? Is that what you are fighting all the time with your overwork and the 'speed' with which you must beat the giant? What is this giant?"

"He was hideous. I suppose I started fighting him at fifteen when I plunged into business on my own and gave myself no time for any evil thoughts or practices." Pause.

"As a matter of fact, doctor, this is not quite true. I had already got up to one or two sexual tricks. I had tried things with girls older than myself, but I got into an awful state about it. And there were real dangers about. My father's bankruptcy and the question of the wherewithal to live, food and shelter, made such distractions as sex as dangerous as the pit or well in my phantasy. I had to stop all that and deal with reality. I was in an awful state of fright on every score, and the only way I could deal with it was by working for some sort of material security.

"I felt I was fighting for life. Father had failed; it was up to me. By God, I did it, and I have done it ever since until this damnable collapse. I must get back to work at once.

"I suppose I have been all right these past two years because I have been *anticipating* marriage and all that it meant to me. But suddenly, on the journey that Friday night, all these anticipations finally collapsed. That is when I collapsed. I went to pieces immediately after. I suppose thinking of marriage

must have been a safety-valve for all that I had bottled up, and I may tell you successfully bottled up, through the help of hard work and the anxiety which drove me to it.

"Oh, yes, I know all the doctors attribute my breakdown to overwork, but now I am beginning to see that overwork is itself a defence against something that I am frightened of. I see what the giant in the dream is. I had to fight him with great speed because I was so frightened.

"Already I am beginning to appreciate that the giant is only one aspect of myself. Now I remember I dreamt that dream again, but with this difference: when I realised that the speed of my fighting would only tire me out I stopped fighting—and there was no fight. The giant did not go for me at all.

"Perhaps this is the solution which slipped past me when I decided that my fiancée was no good for me and that I was no nearer the resolution of my problem than I had ever been. After that I collapsed. There is no sexual life for me. It must just be work and more work."

ANALYST: "*Or work and collapse and then more work and more collapse.*"

Psychopathology: How often do we hear the term "overwork" used as the alleged cause for a nervous breakdown! Not only is it the most popular theory, but one meets it even under the auspicious scientific term "aetiology" in orthodox medical works written by authors who should, but do not, know better.

Frankly, I am sick of it. I make no apology for this emotional expression. Any scientific investigator who met, as I do, case after case where the breakdown was attributed to overwork and investigated these cases would be as sick of this short-sighted view as I am.

What do we mean by overwork? Do we mean that some external influence, such as a slave-driver, kept whipping the unfortunate victim into doing more and more work until the demands of this tyrant imposed such a strain that the poor victim collapsed under it? If we mean this we are mistaken, for the days of overt slavery are over, at least in democratic countries.

Analytical investigation shows that this conception of slave-driver and slave is true only as an *intra-psychic* phenomenon. In other words, the slave-driver as well as the slave exist only within the mind of the individual who becomes the victim of

nervous breakdown attributed to this cause: overwork.

The real psychopathological problem is not solved by saying the man broke down from the effects of overwork. Instead, the all-important question is raised, "Why did he overwork and what drove him to it?"

It is found that an external factor is never responsible. It is always some element within his own psyche which drives him. The cause of this element, what brought it into being and what maintained its activity, is the real problem to be faced before we can understand the cause of the illness.

In other words we must ask the question: "What impelled this man to drive himself so that life became such a perpetual strain and effort that nature could not bear it and breakdown sooner or later was the inevitable result?" The whole interest of the subject lies here.

What drives him to it? Why cannot he leave nature alone to follow its own bent? Its own bent would include at least sufficient periods of relaxation to ensure the maintenance of health. It is found that this he cannot do. He cannot relax. He must go on driving himself not to safety and security but to inevitable breakdown.

That *compulsion* is his illness. It is the cause of this cause which the detailed investigation of every case will reveal to us.

"Overwork" is merely a symptom or manifestation, like the other symptoms of the illness, of a cause or complex which lies concealed in the unconscious mind of the victim.

When this boy reached the age of fifteen, his developing sexuality naturally tended towards some primitive expression. This was so out of keeping with the realities of the economically dangerous position in which his father had placed him that it was fraught with even more anxiety than is normally the case in adolescence.

He was not one who could fiddle while Rome burned. His mind was sufficiently mature and alert to compel him to deal with the reality situation. In a sense he over-dealt with it. *He transferred all his anxiety from its sexual source on to the apparently real world around.*

He had to deal with the problems of food and shelter not only for himself, but for his father. But gaining security merely in the reality situation was not enough.

Reality was indeed only a peg upon which he could hang his

anxiety emanating from sexual unconscious sources. Therefore he used these realities in which to work out the unconscious patterns of compulsion, conflict and anxiety. In short, he expressed his sexual pattern not as sexuality, but as business creativity.

It was a grand sublimation. At least it was an attempt at a grand sublimation. The only trouble was that its roots were ignored.

We cannot successfully fight an enemy by boxing with his shadow. In this case the sexual impulse was the real "enemy" and the shadow was the reality on to which he projected it. Thus he obtained his thrill not by romance, love or sex and the form of creation which nature had designed, but only by creating substitute or symbolical forms of the same thing in the material world of business and economics.

Nature is not to be put off by such subterfuges. He may delude himself, but Nature is not satisfied. However big the business expansion there is never complete satisfaction, or even adequate relief from nervous tension, such as Nature obtains on her lower plane in the form of orgasm. Therefore sooner or later the giant strikes back.

The compulsion is common both to the instinct and to its substitute form, the work or sublimation. The presence of this compulsive quality gives us a clue that they both spring from the same source, and that the sublimation is more a defence against the instinct than a true sublimation of it. The sequel is also sooner or later inevitable. On the sexual plane it is orgasm, on the sublimated plane it is the same thing in another form, namely "nervous breakdown".

Thus we see that overwork is the tumescent phase of the compulsion and nervous breakdown is its detumescent phase.

Nature has so constructed us that the building-up of ever-increasing sexual tension has its sequel, almost as if by siphon-action, in an inevitable and precipitate unbuilding.

If we insist upon acting out this sexual pattern exclusively in a mental or non-sexual manner, our construction, building-up or tumescence will have its sequel, not in sexual orgasm, but in destruction, war or nervous breakdown.

Therefore I said to this patient: "Your life will be more work and more collapse . . . unless you cease to fight the giant . . . unless you realise that he is yourself, your essential self, the

source of all your strength and the father of your children-to-be."

In the case which follows, though it begins with a similarly dramatic symptom, indicating a relationship with the preceding case, the psychopathology will be carried to a somewhat deeper level.

CHAPTER X

HYSTERIA

"This is hysteria; to dramatise the conflicts, if possible directly in the appropriate bodily organ, or as a next best thing in some portion of the body which takes on the symbolical significance of this organ. That is why the Greeks named it 'Hysteria'—literally 'a wandering womb'."

Major Hysteria: The well-known woman Parliamentarian and social reformer lay unconscious in the pathway outside her hotel. She had been ailing for several weeks and had come to this place to regain her health and, secretly, to obtain some peace from the intrusions of various turbulent members of her family.

Her hope had been in vain, for they had all individually and collectively followed her down there. The rows and quarrels from which she fled had also followed her. Her last memory before the collapse was that of her younger son having a shouting quarrel with the young woman whom she had befriended and taken with her as companion. She was trying to rest in the room upstairs while their raised voices assailed her.

Her husband had arrived and joined in the quarrel. Now he and her son had gone to the station. She had come as far as the front door to see them off. The son, still in a temper, had left her with an angry remark.

They disappeared round the bend. That was all she knew. Now she could remember she had had a strange sensation of losing the power of her legs . . . and then . . . nothing.

She awoke in a nursing home with no less than three doctors leaning over her bedside. She was conscious merely of agonising pains, pains that twisted her abdomen into knots and ran down both her legs—colicky feelings, twitchings and aches. Moreover these did not improve. Other doctors were consulted. A specialist from London was sent for.

By this time an idea had arisen in the mind of at least one of her medical attendants that this patient's symptoms fitted into no orthodox medical category. He suspected functional disturbance, but the problem was how to convey this suspicion to

such an important and intellectually dominating woman, or to find a way of "shaking her out of it".

This doctor figured it out that it required some eminent member of the profession who would be in a sufficiently strong position to come and practise the traditional face-slapping or jug-of-cold-water type of treatment, and by the virtue of his eminence get away with it. Accordingly, he sent for his selected neurologist.

The lady told me subsequently: "When this man arrived I took an instant dislike to him. He was too well-dressed. His tie, handkerchief and socks matched too well. I hated his monocle, his collar, his tie, his face and everything that was his. And I think he hated me too.

"Anyhow he took a book from the shelf and hit me on the back of the neck with it. I screamed and got much worse. Now I come to think of it, it makes my blood boil. I fancy a little more, and I might have forgotten my paralysed legs and got up and torn him to pieces. It was either that or getting much worse, and I chose the latter.

"My husband came down and fussed around the nursing home and played the rôle of the devoted husband, but I could see that he was more devoted to the nurses than to me. He thoroughly enjoyed himself. I could have told them some things—but I was too near dying, or crazy, or both. Anyhow, it was finally decided that I would die if I remained in the nursing home, and so I was removed to a large flat at a seaside resort which a friend placed at my disposal.

"There I had a fiery Ulsterman for a doctor. The agonising pains were still in my legs, and I was still raving instead of sleeping. He told my housekeeper that he had the very thing. I was given an injection. He was called that same night because they thought I was dying.

"In the flat above a party was going on. The radiogram was blaring away. They had a number of guests including sailors. There was dancing. The doctor looked at me, his dying patient, and said, 'That noise must stop.' He dashed upstairs to stop it himself. They refused. I heard the raised voices and then the noise of a scuffle or fight.

"It was like old times. They all thought I was unconscious, but I heard everything and struggled with the idea that I should get out of bed and take the doctor's part."

Here I could not resist the interjection: "*Oh no, you were already playing your own part very well indeed!*"

"Presently the doctor was back in the room spluttering with rage. He telephoned the police station. But the radiogram did not stop until the police arrived and turned it off themselves. They placed the entire household and visitors, twenty-five people in all, under arrest. The doctor went off still spluttering, and two policemen stayed all night in the passage outside my room.

"In the morning there was more excitement, for a group of the guests tried to make a get-away. They started up a car at the back and nearly did the trick, only two police jumped on the running-board. I could not resist sticking my head out of the window at this, but it did not matter for at the moment everybody's attention was distracted.

"They were all lined up at the police station and all fined. There was a great deal of hysteria. Several of the girls cried and said they were sorry, while other people said they were glad."

ANALYST: "You had engineered a masterpiece."

"To tell you the truth, doctor, it was very reminiscent of those scenes that used to occur when I was a child at home. But I had never thought that I was going to be the victim of them after all those years of relative tranquillity. I never thought that when my sons grew up we would have all this hysteria in the house again.

"And then that wretched girl. People had told me she was no good, but I still would persist in having faith in her and trying to get her to make a success of her life as I had made a success of mine, or thought I had. But she showed her true character when I got ill, for she went to London and left me to it.

"Anyhow, a lot of people stuck to me and had quite a good time. There were all the doctors and nurses and night nurses, and my husband, whom I had seen nothing of for ten years, running around and enjoying themselves. It seemed that now I was *down* this is what my husband had always wanted, and he was *up* with a vengeance.

"Now I come to think of it, that is why I turned from him, because he was everlastingly trying to get me down, me and my boys. I lived with him for the boys' sake, only to find ten

such an important and intellectually dominating woman, or to find a way of "shaking her out of it".

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"Now I come to think of it, that is why I turned from him, because he was everlastingly trying to get me down, me and my boys. I lived with him for the boys' sake, only to find ten

years later that these same boys, having grown up, were like their blessed father—all determined to go for me and bully me.

"I was too strong a personality for their liking, none of them could stand it. It is a tragedy to be a 'clever' woman. Other women resent it and men dislike it, and of course I have not even the consolation of being clever. I am just different from the others—brought up in poverty, half starved, with hysteria all around me, my mother quarrelling with my father, my father getting drunk, no money in the house, my despicable sister having all her uncontrolled emotional affairs.

"Somebody had to pull themselves together. I did it. I made a success of my life. I supported the lot, the worthless lot of them, and did they love me for it? No. People only love those whom they help. They hate people who help them.

"Evidently I did not learn my lesson. I married a helpless fool of a man who resented the fact that he was intellectually and economically dependent upon me. My children were necessarily dependent upon me, and they were the only people who did not resent the fact, that is to say when they were young.

"But with their growth to manhood my two sons also seem to have turned upon me, especially the younger one. I simply cannot understand it. Perhaps it is that I just cannot bear it. And so now I have been in the hands of the doctors for a year and nine months. They at least have fussed around me and tried to make me better instead of trying all the time to knock me down, as everyone else has done.

"However, it seems that those who tried to knock me down have at last succeeded, and all the efforts of the doctors have been in vain. I cannot tell you all the things they have tried to help me. I have had hundreds of different examinations, X-rays and blood tests, and stuff taken from my backbone—spinal fluid they called it—a horrible experience. And then, in that second nursing home, they operated upon me.

"Nothing has been any good. And so at last, contrary to their advice and in spite of all their warnings, or perhaps because of them, I have come to a psychologist. Every doctor has told me that that would be fatal in my case. Anyhow, here I am. Perhaps I want it to be fatal."

It appears that the patient's anxiety was well founded, and that "all the doctors" were in a sense right, for the patient had not attended many sessions before she did become very much

worse. She telephoned to say it was quite impossible for her to attend her next session as the pains in her legs had become intolerable and she could no longer struggle out to a taxi.

I replied: "*Well, in that case crawl out, but come you must by hook or by crook.*"

She came. She flung herself about, refusing for a long time to recline on the settee. Finally, when she did relax, I asked her to describe those intolerable pains in her legs.

She said: "It feels just as though they were being torn away."

I said to her: "*Now what is your association of thought to that idea?*"

Her reply was astonishing. She said: "I think of my two sons in the Far East. For all I know they may be wounded and suffering."

ANALYST: "Your legs are suffering."

The patient went on: "I have always felt other people's pains and troubles to an astonishing degree. When I read of any tragedy I feel as though it is at that moment happening to me. I feel it as though it is absolutely real. I have only to read of a murder and I actually experience the sensation of the knife or whatever it was.

"All the suffering that people endure I feel is my own suffering, that is why I became a social reformer and devoted all my energy to remedying that which I myself could not endure. I had it all in my home life, and though I have socially and economically avoided it, I have not really escaped it at all. It is still with me, within my very inside.

"Nobody can understand these things. I can. Perhaps I do more than understand; I experience them, I feel them. I feel every body's pain. I cannot pass a butcher's shop because I feel myself like the meat hanging in his window. *It is just me.*

"And then these doctors come along and give me things to prevent me from being me, with the result I am worse, crazier than ever I was; but however crazy I am, I am not as crazy as they are. I know what they are thinking and what they are feeling. I can sense their anxiety before they get it themselves, and on top of it all I feel it is because they have failed utterly to understand.

"Of course, I would not correct them—not for anything. They would not understand. I would just as soon tell my husband. But all this cleverness of mine does not help me to

get rid of the pain in my legs. How can I get rid of that?"

ANALYST: "Let me be the last to suggest that you should get rid of it. However painful the association with your sons may be, it is preferable to have some association with them than to be rid of them."

She went on to say: "That younger boy had been giving me a lot of trouble. I cannot understand what could have possessed him. He showed me a photo of his girl. I praised it, said how sweet she looked, and so on, and then, suddenly, he snatched it from me, tore it up and threw it away, raved at me, and left the room, slamming the door behind him."

ANALYST: "Instead of praising it you should have torn it up and slammed the door on him. You are his only girl friend. What is the matter with him is that he is sexually frustrated on that very account. That is why he is constantly attacking you."

PATIENT: "He calls it 'plastering' me. I never before heard such a vulgar phrase. Little did I think that I would get such treatment from this son. And not only from him but from his brother also, though he is the worst. And that fool husband of mine is no use in protecting me from it. How my legs ache! Most women would call it a heartache, but with me it is my legs. I feel they will really be torn off before I am finished with this illness."

Things went from bad to worse. At the next session it was no longer the legs which were the centre of the picture. Something worse had happened. She now had the most excruciating pains in the lower abdomen. This was the condition for which the surgeons had previously operated upon her.

She kept screwing herself up and rolling about on the settee. In fact, her antics and posturings were to me faintly reminiscent of scenes I had witnessed during those weeks when, as a senior student, I had worked at what is called "The District".

I found myself leaning forward to watch carefully this performance. Presently something occurred to me. I said: "*What does this pain in your stomach remind you of?*"

She answered with the directness which was characteristic of her when she spoke the truth: "Childbirth."

"I have had two children and I know it is exactly the same."

ANALYST: "When did you last experience this pain?"

"Twenty years ago when my younger son was born."

ANALYST: "Of course! But I meant more recently in the course of this nervous illness."

PATIENT: "Oh, that was a few days before I collapsed. It was in the garden of that country house. My son had been going for me as usual. He said the most horrible things, walking beside me and raving like a madman. What it was all about goodness knows!"

"Of course, I had insisted that he should obey his country's call, should not try to get out of service abroad, which his father could have got him out of. They had both gone for me and said I was inhuman, a monster and so on. I think on this occasion he had said his blood would be upon my head.

"He was about to leave the country with his brigade. He shouted at me and rushed off saying he hoped he would never see me again. I was alone. . . . I looked up and saw the tops of the trees outlined against the darkening sky. It was summer and approaching blackout time. At the same moment I got this awful pain in the lower part of my stomach."

(Silence.)

ANALYST: "*What is your association of thought?*"

PATIENT: "I was thinking as I thought then—a similar scene twenty years ago. I was similarly disturbed emotionally. I had been walking up and down my room all night. I had been told not to send for the doctor before it became really necessary. I had been having periodic pains in the lower part of my stomach throughout the night. They were getting worse.

"I looked out of the window and saw the tops of the trees against the lightening sky. On that occasion it was dawn, not sunset. The pains grew worse, and I remembered no more. The baby—that same baby that had been raving at me—was born before the doctor had time to arrive.

"But now I have passed my menopause. What are these pains that are going on inside me now?"

ANALYST: "*I expect you are again getting rid of the brat. Perhaps it is about time! With all your conscious-level ideals of making him independent of you, you and he both feel that you have kept him within your womb ever since. You had best turn him out finally and let him have his freedom for better or for worse.*"

The worst was not yet over. At the next session the patient complained bitterly that these pains, these childbirth pains, had never left her. They had kept her awake and in agony for two days and two nights.

She said: "Can't you give me a sedative, doctor, or an

anaesthetic, or put me to sleep in a nursing home, or something like the other doctors did? I simply cannot bear this going on as it is."

ANALYST: "You appreciate, or I hope you appreciate, that it is nothing more or less than childbirth—and a phantom baby at that. It is nature at work and cannot do you any serious harm."

"But it is most terrifying."

ANALYST: "What is terrifying?"

"At any time it may develop into that terrible state of frenzy which I had in my previous attack."

ANALYST: "Frenzy, what do you mean?"

"Well, when I cannot bear this pain any longer, as at my first breakdown, I go perfectly crazy. I just cannot bear it. I scream the place down and I throw myself about in an utterly uncontrolled manner. I really do not know what I am doing. I fling myself and everything about. It is most dangerous."

ANALYST: "What is the association of thought to this uncontrollable frenzy?"

(After a moment's hesitation.) "That was when the child was actually being born. I never had an anaesthetic. At that moment I lost my senses and flung about hysterically, screaming and frantic."

ANALYST: "Well, in that case the sooner you have the frenzy and get the birth over the better; the sooner you will be restored to health. What is delaying you so?"

"Why, I could not do a thing like that. It would be most undignified, disgraceful, I have some appearance to keep up. Whatever would my housekeeper and the neighbours think of me?"

ANALYST: "Well, you know they are a lot of fools, anyhow. What does it matter what they think of you? Give birth to your child and be done with it. Have it now, here, on this settee."

This was a new and perhaps intriguing idea for the patient. Unfortunately, the time at our disposal was inadequate for childbirth. The clock struck, and I showed her to the door, frenzy and all. But ere the clock had struck the next hour her housekeeper was interrupting my subsequent session on the telephone, saying: "What shall I do about my lady? She is screaming the place down and the neighbours will not stand it."

I replied on the telephone: "Don't worry about the neighbours, it will soon be all right."

An hour later the birth had not yet been completed. I spoke to the patient on the telephone. I said to her:

"At your actual childbirths, however much you may have dreaded and tried to hold back the final emergence of the baby, nature was too strong for you and brought it about so that it was all over within a short time. But in the case of this phantom baby your resistance is proving more successful. You are holding back the climax. You are refusing to let nature take its course."

"My advice to you is simply to relax and let it all take place. There will be no real danger—even in the absence of the doctor in this case. It will be interesting to come tomorrow and to deal with the psychological aftermath of this phantom labour. Do come. We will enjoy it."

Psychopathology: She did not come. Nature, or her addiction to nature, proved stronger than the claims of psycho-analysis.

This patient was one of a family whose id drives were generally too strong for ego control. Most of its members flung their impulses and emotions around to the detriment of reality adjustment. In her case the behaviour had, at least until recently, been different. She had confined her id drives to phantasies of social improvement, and not without a considerable practical application of the phantasies. Hitherto she had successfully suppressed their superabundance, while at the same time she had formed excellent reality adjustments.

On reflection it seems that more of these id impulses than she was aware of had been absorbed within her marital life, and in the course of the physiological activities of conception, childbirth and motherhood. But this was all very long ago. No doubt the struggle to keep their superabundance suppressed was becoming progressively harder. The psychological task had been rendered even more difficult, impossibly difficult, by the fact that for several years she had ceased to cohabit with her husband.

Not only was the id no longer being satisfied by the physiological activities of reproduction, but also it had long since ceased to achieve a reduction of tension through the ordinary processes of sexual gratification. Phantasies and sublimated activities remained.

Her enthusiasm for social reform and family interests had absorbed just sufficient of these tensions to exclude symptom-formation, but now with the evident failure of the absorption

of her affections within her family these sublimated structures were proving a forlorn compensation. They were ceasing to gratify.

At the same time, the very child to whom she had hoped to attach them was flinging them back in her face. She had, as it were, to eat her own words—more than that—to swallow her own emotions and her own chagrin. The internal disturbance proved too much for her ego control. It proved too much because this control already had as hard a struggle as it could endure.

If we could look deeply into her psycho-physiological structure, we would see that this was a woman whose body-mind could only be satisfied while it was absorbed in its dynamic psycho-physiological purpose. One of the most striking things she said was this: "The period of my life when I have been most contented, indeed the only time that I have been fully contented, was when I was actually pregnant. I never wanted to give birth to the baby. It almost seems to me that I wanted to keep it inside me for ever. I felt full and satisfied while I was carrying it, and the larger it grew the more contented I became. It seems that that was the only satisfactory state for me."

Now if she is suddenly deprived of her *compensatory* satisfactions, however relatively slight these may be, this woman's id reverts back to the one period of her life which was not merely compensatory, but which was adequacy itself. She again goes back by means of a pseudo-physiological performance to console herself, to satisfy herself, with the condition of fullness. Indeed, her case history suggests that she had never really been free from this fullness. She had carried it within her womb ever since the birth of her last baby.

I cannot trace outward manifestations of this carrying of the now growing son within her womb, but there is evidence that he himself felt it in no uncertain manner. He wanted and expected her to move heaven and earth to keep him within the family circle, or within the psychological womb. He could not understand that she should put the country's need before his and her need for this unconscious "incestuous" intimacy.

His aggression was unloosed. He "plastered" her. Her womb responded by turning the now uncomfortable embryo out into the world. It had kicked a little too hard. But there was no satisfaction in this pseudo-labour. Everything associated with

it was agonising. She felt the agony in the appropriate place—her womb.

The one thing she could not bring herself to do was to permit the process to complete itself. She could not permit the final act of childbirth. The conflict within her centred about this original maternal function. Part of her strained to eject the intolerable discomfort, and part of her held back the expulsion.

There was a state of womb colic. The doctors could not understand it. They deal with signs of pregnancy, not phantasies of childbirth. She *could* understand it, but she did not want to. It was a more emotionally gratifying situation to experience it.

This is hysteria; to dramatise the conflicts, if possible directly in the appropriate bodily organ, or as a next best thing in some portion of the body which takes on the symbolical significance of this organ. That is why the Greeks named it "Hysteria"—literally "a wandering womb". The pains in her legs, representing her two sons, were an instance of the latter process. It felt as though they were being "torn away from her". But this, her last born, was being extruded from her womb and at the same time held back within it. The process continues

At this dramatic point we must leave the patient for the time being. I hope that I shall find a subsequent opportunity for depicting the future of her illness.

Nevertheless, I must point out to the doubting Thomases (the men rather than the women) that the experienced psychologist has no doubts about the ultimate efficacy of the psychological method. Those who base their conclusions purely upon the superficial appearance of things without any insight into the deeper causative forces must conclude that analysis has, at least up to this stage, reawakened the sleeping dogs of her disorder and obviously made the patient worse.

It is, I suppose, on account of such experiences that so many doctors tell their patients, "Whatever you do, don't go to a psychologist. You will become much worse if you do."

The simple truth is that the "badness", the id, is already there in any case, and the fact that the patient has symptoms, dormant or obvious, is a clear indication that the forces and phantasies responsible for these symptoms are pressing for freedom—like an abscess or carbuncle oozing out of the encasing skin and tissues.

What surgeon seeing such a condition would say, "For heaven's sake let sleeping dogs lie! If the pus is not visible let us pretend that the abscess is not there"?

Yet when the "abscess" is a mental one this is precisely what they do say. It is so much easier for them to shut their eyes to the pressure of mental "abscesses".

The psychologist is one who has had his eyes opened. He knows that the apparent disturbance, the worsening of the condition in the throes of treatment, is an inevitable prelude to at least a betterment of the ultimate condition of the patient.

The more pus that comes out of that abscess, no matter what emotions and anxieties its emergence may cause, the better the ultimate condition of the tissues from which it has emerged.

Therefore he does not worry while the patient and all the doctors rave, or even while they try with drugs and what-not to stem the flow. He knows that the pressure of nature is stronger than patients and doctors combined. They may retard it and thereby prolong the patient's incapacity, but dam it up permanently they cannot.

Nature will go on. She will continue to live. She will continue to produce her babies with or without our conventional acquiescence.

Hence I have no regrets at having again stirred up the forces which originally precipitated this patient's first breakdown some years ago. She had never successfully dealt with them. Throughout this long period she had been at least semi-invalided. Whatever was pressing to come out of her had been partly pressed back. There has been no solution of the conflict one way or the other. She had come to me because the position seemed to be illness *in perpetuum*.

What had I done? I had brought the struggle up again to the conscious level of her mind—the drama of it, the emotions of it, the vivid re-living of the whole thing in its entirety. But with this difference, that she now had a good promise of full insight and understanding. The vividness of the whole thing made it imperative that she should, and with her insight she can, settle the matter one way or the other.

If she refuses this resolution she will have in the meantime, in the course of this acute exuberance of symptoms, discharged at least a portion of the pressure and to that degree reduced its tension.

She will be better. Not so well as she would be if she continued her treatment and evacuated the whole thing. Nevertheless she will be better—better than she has been during the years since her first attack. Of course, it may be some little time before the partly discharged abscess settles down and heals over the remaining pus.

It will be just long enough for those who put on the soothing, healing bandages to be given the credit, and for the surgeon who opened the wound to be successfully reviled. This is inevitable until increasing enlightenment shall make mental maladies as obvious as surgical ones.

There is only one word of warning which should be uttered in such particularly dramatic cases. The diagnosis of hysteria, though it may well exclude the possibility of organic disease, does not exclude the possibility, nor, indeed, the likelihood, of an underlying deeper and more serious mental illness.

In such cases the outcrop of hysterical symptoms is, if treatment is continued, often a prelude to the emergence of the graver mental disturbance. Nevertheless, one's experience is that a relief of this outer bastion of tension, far from precipitating the graver complaint, may act as a successful safety-valve and save the patient from total mental breakdown.

Cases exhibiting such very severe hysterical manifestations are not the commonest experience of the psychologist. But a large number of them have been recorded and a very much larger number have been completely missed or misunderstood by the laity and by the medical profession. There is one particularly famous case on record: that of Mary Tudor, unjustly referred to as "Bloody Mary". Her life story had been sufficient to render the hardiest soul psychoneurotic, and, coupled with her inheritance, there is small wonder that by the time she came to the throne she was a more or less confirmed mental invalid. In 1554, within three or four months of her marriage, she proclaimed herself pregnant and the occasion was celebrated in the diocese of London. It proved to be a delusion. In 1558 there is evidence that she was again suffering from this delusion. She made a codicil to her will revealing that she was chiefly concerned with the dangers of childbirth. Within a few months she died. There was at no time any evidence of pregnancy. It is more likely that the repeated illnesses from which she suffered were similar to those of the

patient whose case-sheet I have here recorded, and there is no doubt also that they similarly confounded a succession of doctors. We know too that nervous disturbances can so disorganise physical functioning that they can arrest menstruation for as long as nine months of pseudo-cyesis, terminating in pseudo-labour, and can even pave the way for death from both mental and physical causes.

In the case of my patient I have every reason to believe that whatever psychotic elements may have been present they were a very small part of the whole, the hysterical mechanisms absorbing the vast proportion of her libidinal energy.

Unfortunately for the extension and completion of this case history I was not given the opportunity of tracing the psychopathology back to the organisation of her hysterical disposition at the Oedipus stage of libidinal organisation, but we have seen from her few references to her childhood, the emotional disturbances within her family circle, that there was, apparently from birth to adolescence, a very rich soil for the development of intolerable emotional tensions and abundant infantile traumata. No doubt in due course analysis would have revealed that her current disturbances, and those of twenty years ago to which they have been associated, are all essentially later editions of earlier emotional patterns traceable to their origins in the forgotten period of infantile amnesia and revealing early ambivalence and acute conflict in her emotional relationship to parents and family at this impressionable stage of development.

However, I am confident that what little treatment she has had, albeit very inadequate, will ultimately result in that degree of improvement of her previous invalidism.

CHAPTER XI

THE BEGINNINGS OF HYPOCHONDRIA (SIMULATING GASTRIC ULCER AND SUG- GESTING A PRE-ULCEROUS CONDITION OF PSYCHOLOGICAL ORIGIN)

ONE wonders whether the term hypochondria should be retained at all in scientific literature, however useful it may be as a symptom category in general medicine. We have seen how tension arising from somatic sources, specifically from inadequacy in psychosexual orgasmic relief, can give rise to mental tension or anxiety neurosis. We have seen how this tension can not only overflow directly into a variety of somatic innervations, but how it can also reactivate unconscious complexes and repressed libidinal fixations. We have seen how the dynamic energy of this tension can then flow through the psychological paths of these repressed constellations and psychic patterns and overflow into symbolical bodily regions, giving rise to symptoms which are complained of as physical. We have seen that with a development of this process the energy can be more or less diverted from mental channels into physical, so that finally, if not initially, the patient may be totally unaware of any mental stresses, may, in fact, deny these and present himself merely with a simulated physical disorder. Essentially this is the mechanism in hysteria.

But often when the process has passed from any possibility of recognition by the patient, or a vehement denial of it, as a mental phenomenon, he may induce his doctor, similarly biased by virtue of his intensive education along physico-chemical lines with rigorous exclusion of mental phenomena, into a similar degree of blindness. Cases whose symptom-presentation is particularly prone to achieve these ends, are, when all physical investigation ceases to reveal results and when all surgical and medical treatment fails to achieve any amelioration, finally classified by the practitioner as hypochondria.

Thus it will be seen that they are often really nothing more or less than a particular form of hysteria, and examples of cases

manifesting a tendency in this direction, via the mechanism of conversion, are included under the heading of The Hysterias. It should be added that some hypochondriacal symptoms can, and commonly do, arise in almost every variety of nervous and mental illness, particularly in involutional melancholia and in some cases of schizophrenic and paranoid psychoses. This is only to be expected if we regard psychogenic disorders as having a common root in tension or anxiety.

The following case, though essentially one of hysteria, introduces us to the method of production of conversion and hypochondriacal symptoms, and the case after that (Chapter XII) shows us some of these symptoms in a more developed condition.

The other day I was consulted by an exceptionally brilliant medical student; a Viennese. He began by telling me that he had no faith whatsoever in psychology.

He was in great distress. He had even been thinking of suicide. It was because he was suffering from an acute gastric ulcer, and had now lost so much weight that he felt he had not long to live.

"In the last six months I have become a skeleton; and after everything I eat, even milk, I have this terrible pain. It is, I am convinced, an acute ulcer. There is no imagination and no psychology in it."

I said to him: "Then why have you come to consult me: a psychologist?"

He then told me the story of the rabbi who, on his deathbed, asked them to bring him a cross that he might kiss it. When they protested that he, a rabbi, should have such a desire, he replied: "Why leave any stone unturned? There may be something in this too!"

"I have tried all the specialists in organic diseases without benefit. And so I suppose I have now come to kiss the cross of this nonsense!" said the patient.

This was the basis on which our consultation began, and this was largely the basis upon which it continued. Despite much dissembling the following coherent story eventually emerged.

He had always been a man of very great energy.

"I work very hard, doctor, and I keep very good health, but whenever it stops—the work or the health—I immediately think of suicide. My father's brother committed suicide, also my only

brother. And my father died of gastric ulcer.

"I must confess that I have always had worry, and that I have always been preoccupied with sex. Sex has never been a pleasure. It was never a free thing, that is free from worry. I always had fear, fear and fear. There is the fear of impregnating the girl, and then, if I did not have that, there was the fear of venereal disease. Even, apart from both these, there was the fear that the girl would catch me somehow, and I would have to marry her.

"I am telling you this as I shall have to tell you that sex worries have nothing to do with my illness. A year before my illness started I seemed to have solved this problem. I had found a girl with whom I had practically none of these anxieties, except perhaps a little of the last one. And that six months had been the best period of my life."

ANALYST: "*And this last six months has been the worst?*"

"It most certainly has. Seeing you is the last resort. I had said to myself: 'I will put off the suicide for a few months until I give this a chance.'

ANALYST: "*Well, six of the best months of your life, and then six of the worst! You should soon be back to normal again.*"

Ignoring my remark, he continued:

"But my trouble has nothing to do with sex! I am telling you this, that I had practically solved my sex problem better than ever before, before this trouble began, in order that you will not make the mistake of thinking it has to do with sex. On the contrary, when I had this girl friend I had practically no sexual worries. I was cocky and independent."

ANALYST: "*You were 'cocky'. You are quite right when you say this trouble is not sex. It is the opposite. It is castration.*"

"Nonsense!"

The story which I eventually elicited from the fragmentary utterances of this patient was as follows:

For several months he had been indulging in regular sexual relations with this young woman friend. On a Friday she had left him to join one of the women's services. On the Saturday, the day after her departure, he had an acute irritation of the skin. He decided he must have scabies (the itch) and he was in a great state of anxiety that he must have given it to the young woman, who would spread it throughout the camp. It had nearly reached the magnitude of a national disaster!

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The following day this anxiety was so great that he went to a skin specialist, who confirmed that there was no sign of scabies.

On the next day, Sunday, when the girl normally would have been in his company, and they would have had sexual relations, he was in an exceptionally excited state. He absented himself from his meals, and worked on until late at night. Then he had a small hasty supper, consisting of sardines and bread, and went to sleep.

He awoke two hours later with acute abdominal pain, and was immediately convinced that the meal he had eaten had poisoned him. The following day he developed the idea of gastric ulcer, and began to diet himself. Alkaline medication had no effect on the pain, nor indeed had diet. This led him to the conclusion that the "ulcer" was acute, so he consulted a specialist.

He was admitted to hospital for investigation. For three weeks he had been subjected to careful physical examinations, including test meals and X-rays. In conclusion the specialist had told him there was no evidence of ulcer, but that investigation suggested some incipient gastritis.

As, by this time, the specialist had suspected an adjuvant nervous factor, he labelled the illness "Hypochondria" and got the hospital psychiatrist to see him. The latter promptly changed the label to "Psychosis" and suggested electrical shock therapy. But the patient did not wait for the electrical apparatus. The suggestion itself produced sufficient shock to shock him out of bed! And this is what brought him to me for consultation.

Material provided at the analytical sessions by his unconscious mind is so strikingly in contrast to the expressed opinion of his ego that I think we should waste no time in getting into touch with the former, in order that we may place the latter in its true perspective.

At quite an early session he brings me the following dream:
"I have a friend called Gladys, who has recently got married. The dream was that I went to her house, and she had a whole table laid out with food, as though the articles of food were wedding presents. I told her, 'Do you know the way this table is laid out has some special psychological significance?'"

The patient goes on to say:

"The dream just serves to reflect my present condition—food-conscious. In the centre of this table there was a special dish of

fish. The dish was special and the fish in it was special, and it was in the centre.

"I lifted it up to see what sort of legs the dish had, or else to see what sort of fish it was."

"I don't want to believe what you say about this pain being of psychological significance. To me it is a purely physical pain."

ANALYST: "*Free association to your action in the dream, lifting the dish?*"

"I just had to see how the fish was laid out, the way that fish was lying there on a big dish. I always look at things. I always search for details. The whole table was arranged like a table of wedding presents, and the most prominent thing was the fish. I wanted to know if it was on a dish with legs or whether it was flat."

ANALYST: "*What are your thoughts about Gladys?*"

"I am envious a little. I have taken her out in the past. I think she might be a suitable match."

ANALYST: "*And after the wedding you go to her house?*"

"Yes, and I see all this food that I cannot have so easily."

ANALYST: "*When you say you are envious, what are you envious of in connection with her? What would you like?*"

"I'd like to be able to eat food. Of course, *you* mean that I'd have liked to have married her, but I tell you that it is not a matter of sex at all. When I get better from my stomach trouble I shall probably have the problem of impotence to wrestle with, if you keep suggesting that I am impotent."

"I admit I had curiosities about Gladys, and that I was envious of her marriage. Now 'lifting up' suggests to me lifting up her frock."

ANALYST: "*What is the food connected with a wedding?*"

"Sex, of course. But I was interested in the dish."

ANALYST: "*Whether it was a dish with legs or not?*"

"The fish was the biggest thing there, on a nice big table."

ANALYST: "*What is the biggest thing at a wedding?*"

"It is sex, of course. A man lifts up a frock to see the girl's legs. Sex, of course."

ANALYST: "*What is the biggest thing in your life?*"

"It is food."

ANALYST: "*And the dream tells us it is sex.*"

(Silence.)

ANALYST: "*What are you thinking about?*"

"I was thinking that, when I get well, the biggest problem in my life will be impotence."

ANALYST: "So you are making this fuss about food in order to disguise from yourself the idea of impotence and your castration phantasy. Your dream is interesting in that it shows that sex is being disguised under a symbolism of food."

"I deny that. There is only one thing that matters to me at present, and that is food, and the pain in my stomach."

ANALYST: "In your dream you were more of a psychologist than when you are awake."

"I had another dream last night. I was storming a height. That suggests to me the return of vigour and energy."

ANALYST: "Yes, but what are you denying?"

"I am denying that it has anything to do with sex. The dream was that I stormed a height, and the enemy I conquered were Americans, and they were very friendly, because they said they'd rather be beaten by Englishmen than by other Americans. The curious thing is that they were so pleased and I was made so welcome."

ANALYST: "Your association of thought to that?"

"Well, of course, it is all nonsense, it doesn't count, but I did think just then that when I first made sexual love to my girl friend I was surprised that she was so pleased about it. Now I think she has been to America and has an American accent."

At the next session the patient says:

"I have had a number of dreams but they mean nothing at all. Why can't you treat me by reassuring me that my ulcer will get all right? That would be proper psychological treatment. In any case I don't believe that any of this has to do with sex at all."

ANALYST: "Perhaps in the meantime we had better hear the dreams."

The patient is then silent. On enquiry he says:

"I was thinking I would probably give you another dream, and we'd work it out, and it would be the same, and I can't see that it is getting us anywhere."

ANALYST: "What is your association to this feeling of protest?"

"I don't believe my illness has anything to do with sex, and we are just wasting our time talking about it. I am not interested in sex at all in my present condition. I have no appetite for it and I don't want to talk about it. If any patient consulted me

with the symptoms I have got, I would cure him by a strict diet. I believe I had a dream something like that."

The patient goes on to relate a series of dreams which I have numbered and set out in sequence, as they reveal the unconscious factors responsible for his nervous breakdown.

(1) "Somebody consulted me, a man friend who has recently got married. He wanted my advice on something medical, but in the dream I said I'd see him about it later on, that I hadn't much time. And then I said: 'Do you know So-and so? He is one of the thoughtful sort and he has no interest in girls.' "

In answer to the question "*What advice?*" he said:

"I know what you want me to say; but it is not so."

ANALYST: "*What is not so?*"

"It is not impotence. Although now I come to think of it, this married couple were very bored with each other, and I had thought the man must be impotent.

"'Not interested in girls' makes me think that sort of man is impotent. He runs away from sex and becomes one of the thoughtful sort, and I am very thoughtful that this girl friend is losing interest in me.

"When I was well I was the master. I could do without her but she could not do without me. But now it is the other way round. She does not write so often. She is detaching herself from me, and now it is bothering me. Her detachment is a consequence of my impotence. I become dependent, like a child, and now she is the independent one. The greatest detachment would be suicide or death.

"That reminds me that I first had thoughts of suicide at the age of five years. It was at a time when I had no father, and my sister had just been born, and was having all my mother's attention. I felt I was cut off, and I would be better dead. Perhaps all this is linked up with my present illness, though I don't think so. It is a gastric ulcer that I have got."

(2) "I dreamed I said to a girl: 'I don't drink, because I don't want to be irresponsible; but the other thing is different.' "

In association to the "other thing" he says "sex". The ultimate interpretation that emerged was a reversal, as one would expect in a patient so anxious to dissemble or deny what his unconscious was saying. It was this:

"I don't have anything to do with sex, because I don't want to be responsible for the consequences. But if one has one's

anxieties and conflicts in connection with food, that is different, the results are not so serious."

(3) The next dream he declares was about *food*, but he has entirely forgotten it.

(4) Another dream was as follows: "I was in a friend's house, and he had a Turkey carpet for which he said he had paid £10. I said it was a bargain. He said: 'What is your carpet like?' and I said: 'A fitted one.' (Actually I have not any fitted carpet.) 'And it cost a good deal more.' I thought to myself, 'I can never get a bargain because I am not quick enough.' "

With regard to his friend having a bargain, he says:

"He has been most successful in his married life. He has got a bargain there—in his wife. She has lately had a baby."

The Turkey carpet he associates with blood.

Regarding the fitted carpet he immediately produced the surprising association of sexual fitting.

(5) "I was in a train. The train was going on. Before I had arrived at the station I got out and passed across the lines. I had two tickets in my hand, and I did not know which one was wanted. I handed over the two and the collector took one."

In association to getting out of the train before it arrived at the station he says:

"Before sexual excitement reaches its climax I always interrupt the intercourse in order to use contraceptives."

With regard to the two tickets, he says:

"Two safeguards. I always use two contraceptives, as I am so nervous of the consequences."

In spite of these being the only association of thought he produced to this dream, he finished by saying: "I think all these are forced associations; I do not believe a bit of it."

(6) The final dream, dreamed in the same night and produced in the same session, is as follows:

"I am in a room with four other people. Three of them were gangsters, and they were threatening the fourth with revolvers. They drew near to him. Then one of them discharged his revolver, and it all went on the floor. The man showed me a slightly wounded or grazed hand. Curiously enough it was a *raised* wound, about one inch in diameter. I hastily put on a bandage and hurriedly reassured him. I said: 'It's nothing at all . . . soon be all right.' And then I said: 'This will do temporarily.' As a matter of fact I didn't want to have much to do

with them. I wanted to get away from it all as quickly as possible."

In association to the revolver discharging on the floor he referred to Genesis xxxviii, and proceeded to detail an incident of premature ejaculation.

He remarked on the curiosity of the hand wound being raised above the surface, instead of being concave as one would expect of a wound. Though, as usual, no suggestion had been made by me, he protested violently that it was *not* a male sex organ, and showed considerable haste to get on to another subject.

I then pointed out to him that in the dream also he appeared to be in great haste to dissociate himself from the situation.

He got off the settee, asking if the time were up!

I pointed out to him that *I* was not the three gangsters, that we had considerable time left, and that there was no need for him to be in such a hurry to dissociate himself from our analytical situation. Nevertheless he found it very difficult to remain, could hardly keep himself still and spent the rest of the time expostulating that his trouble had *nothing* to do with sex.

Psychopathology: This case presents us with two problems in psychopathology. The first is the question of the source and mechanism of the patient's *symptom*, and the second is the question of the source and mechanism of his *theory*.

It will be seen that the two are in a sense diametrically opposed to each other, and in another sense coincidental.

His symptoms will be seen to have their source in sexuality (or rather in sexual conflict and its attendant castration phantasy) and their mechanism in an opposition to it which causes its energy to be deflected into painful instead of pleasurable experiences.

His theory will be seen to be a product of this opposition, or shall we say a revelation of it on a mental plane. It is nothing more or less than an unconscious attempt to get as far as possible away from the source of pain and anxiety (cf. the patient's hurry in his dream to get away from the gangsters).

It is of course possible to give only a brief representative excerpt of the total material in a case report such as this. Nevertheless it will have served its purpose if the material is truly representative, which it is.

The pity is that our space is limited, for it is chiefly the

enormous and ever-increasing accumulation of circumstantial evidence which becomes so overwhelming in forcing us, despite our resistances, to the only possible explanation of the psychopathology.

Let us review briefly the history of his symptom-formation. He tells us that his sexual impulse had always been to him more a source of worry than of pleasure. It had never become ego-syntonic, that is to say, he had never learnt to synthesise it with the higher levels of his psychological make-up. True love, courtship and marriage had never been an integral part of his personality.

On the contrary, his sexual impulse had always been a force, and in his case a very lively force, which had run counter to the rest of his personality, his ideals and plan of living.

In consequence, when sexuality was indulged in it was as he says "more of a worry than a pleasure". It was surrounded by manifold anxieties and guilt-feelings. These indicated a phantasy, often unconscious, of retribution close upon the heels of any pleasure or relief which his instinct might have been experiencing.

Nevertheless his sexual instinct had for the past six months prior to his illness been experiencing this relief and pleasure. He has said, "I had been happier during that six months than ever before." He had eluded the anxiety and the phantasy of retribution for six months, but not for longer.

Sooner or later this adjustment had to be upset from internal (psychological) sources, if not from external ones. An external source was provided by the girl friend being called up for National Service. This precipitated his illness.

While on an ego plane he congratulated himself that he had avoided the danger of having to marry her, at the same time his sexual instinct experienced a compulsory interruption in its now habitual reduction of tension. This, which was the nearest approach he had achieved to a conflict-free outlet, had now been stopped; and the periodic reduction of tension whereby he had been maintaining a tolerable state of health, now being no longer available, the energy reversed itself and as it were went over to the opposition, the anxiety and guilt-feeling never far distant.

The result, which we see in his case history, was that he immediately suffered from an attack of acute anxiety which he

converted into the symptom of skin irritation and the delusion that he was suffering from scabies.

This proved an excellent vehicle for his guilt-feelings also, as he was able to nurse the phantasy that he had passed on the scabies to the girl friend, that she would disseminate it among the women's services, so that he became burdened with the guilt of a calamity approaching national proportions.

This gives some indication of the load of anxiety and guilt which he was carrying and through which his sexual instinct had to be strong enough to operate, that is if he were to be sexual instead of neurotic.

Further, on the day when his energy would normally have experienced its accustomed sexual outlet none was available, both from internal inhibitions and external frustrations. He endeavoured to disseminate it in overwork, but overwork, however continuous, does not provide orgasmic relief.

That night he had his "orgasm" not in the form of a pleasurable sexual relief, but coupled with all his superabundant anxieties in the form of an intolerable conflict which obtained physical conversion by discharging itself through the autonomic nervous system connected with the functions of his stomach and bowel. He suffered a night of acute gastric pain and colic.

Again his mind proved an easy prey or accessory to these morbid processes and he readily concocted the theory that he had acquired a sudden and most acute gastric ulcer. Of course sexuality was utterly forgotten as though it had never existed.

His experiences, though having their source in the dynamic energy of the sexual instinct, were certainly no longer sexual in the sense of pleasurable. They were in fact the diametrical opposite. In psychology we would call them castration equivalents.

The only complete castration equivalent which was missing was suicide. But even this was not far away. He admitted when he came to me that it was his chief concern, that he had struggled with it for weeks and months, and finally that he had merely put it off for a short while to see what this much-discredited treatment of mine might produce.

It is noteworthy in this connection that his only brother and another relative had in fact committed suicide, doubtless the victims of similar mechanisations to those here portrayed.

Now the psychopathology of this patient was easily discern-

ible in the picture of sexual and castration symbolism which he produced by his free association of thought from his first session to his last. Though he is not consciously interested in sexuality, every one of his dreams without exception, and every one of his associations to the items of these dreams, show us that his unconscious mind is occupied with one subject, and one subject only.

That subject is sexuality, whether represented in the form of food or by other symbolism, and the interference with, frustration or castration of, sexuality. At the beginning we see the unconscious phantasy of castration dominant with its attendant idea of suicide.

As he proceeds we find the positive phantasies of sexual interest, investigation and pleasure becoming increasingly evident. For instance, in his dream he lifts the dish to see if it has legs. His libido, or sexual energy, is again tending to flow forwards into the normal and healthful biological channels.

We begin to see this happening in his dreams and in his associations of thought to them. At the same time we see it beginning to happen in his ordinary daily life. He becomes slightly more interested in the persons and things around him. But perhaps most striking of all he begins to eat normal, healthy meals, whereas previously he complained that even milk gave him acute abdominal pain.

The life forces take more than one form in their movement towards gratification and life. Interest, sexual interest, and good appetite move hand in hand, while lack of interest, impotence, anorexia, gastric ulcer and suicide denoted the previous morbid movement instigated by anxiety and guilt in the opposite direction to health.

Now the matter of special interest in this particular case is that a brilliant and well-educated medical student, on the eve of a higher qualification and knowing practically all that the medical schools and hospitals teach about the pathology of disease, can so fervently nurse the delusion that he is suffering from a specific organic illness, namely acute gastric ulcer, in spite of the negative clinical findings and in spite of all this psychological evidence that his troubles are entirely psychogenic.

Moreover, it is not without practical interest that he has inveigled medical specialists into endeavouring to corroborate his delusions by painstaking attempts to confirm that his

troubles are primarily organic. Session after session he produces accumulating circumstantial evidence that his unconscious mind is preoccupied with one matter, and one only, and that is the conflicting phantasies of sexuality and castration.

The castration phantasy and its attendant anxiety prevent the normal reduction of tension through sexuality and orgasm or even through their equivalent thoughts, anticipation or unconscious phantasy. The result is that tension has no other course but to activate and endeavour to obtain discharge through a castration phantasy with the assistance of bodily as well as mental enervations converting this energy into muscular spasms, organic pains and mental anxieties and delusions.

An interesting point is that while he produces this evidence, and, most striking of all, evidently obtains some relief in its production analytically, with a consequent amelioration of his physical symptoms, a disappearance of his suicidal tendency, a return of his appetite, his mental interests and a gradual restoration of health, nevertheless, he consciously professes in the face of all the evidence his complete disbelief in the sexual origin of his neurosis and is never tired of asseverating that he is suffering from no psychological disturbance, but solely and simply from acute ulcer of the stomach!

What is the meaning of this remarkable mental phenomenon? This is the second psychopathological problem which this case presents for our consideration.

I have avoided calling this mental phenomenon "extraordinary", for it gains in interest from the fact that it is the most ordinary of all mental phenomena. We find that in spite of all evidence to the contrary even the most so-called normal mind is commonly set rigidly against a recognition of the sexual conflicts which lie at the root of its mental disturbances and of its bodily symptom-formations.

Any attenuation of the sexual theory or any opportunity to water it down or discount it in the slightest particular is most eagerly embraced by the majority both of human sufferers and diagnosticians or theorists.

Only the other day a patient whose troubles were as usual 100 per cent sexual was intrigued and tempted by the remark of a friend, who told him that she believed in the Jungian rather than the Freudian theory and that it would do him more good.

Similarly, many are the voices suggesting that psychological

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Similarly, many are the voices suggesting that psychological

theorists should sink their differences and form a compromise between the various leading schools of psychopathological thought. Many are ready to acclaim as broad-minded and full of the virtues those sufficiently inexperienced or sufficiently weak-minded to attempt such compromises with the opposition!

The facts, on the contrary, point in one direction, and one direction only.

Such facts for instance as this patient's persistent denial of the psychogenesis of his illness show us, operating against sexuality, a mental force which in its power and insistence can be compared only with sexuality itself. It is a product of the anxiety and castration phantasy opposed to his sexuality and responsible for the diversion of it into the morbid channels which give rise to his symptoms and to his delusions.

Sexuality produces life both biologically and individually. This other is the force which operates against it in the direction of suicide, or, failing that, in an attenuated form in the direction of all illness, emotional anaemia and general ill-health.

This ill-health can be seen as a physical phenomenon or as a mental one. I would include in this latter category the anaemic theories which divert interest from the only direction in which an understanding of the phenomenon of life and death can ever hope to reach a solution.

As I have indicated, the physical symptoms from which this patient suffered gradually disappeared under short psychological treatment.

But although his physical health was restored, I would not regard his case as a complete cure. He reverted to an expression of the positive side of his sexual instinct in the activities natural to him when in a state of health, but he nevertheless showed that the conflict, the source of all his troubles, was still unresolved. He continued to express the other side of this conflict in the mental symptom of an intolerance of his own sexual conduct and a repudiation of the theory of sexuality as a source of such symptoms as those from which he himself had suffered.

In his case the body of the facts proved amenable to cure while the phantasy of theory remained interestingly intractable.

Further analysis showed that this opposition had transference significance and was associated with a phantasy of resisting, and of castrating, the father imago—the only bit of "potency" which he could hang on to in his castrated state.

Medicine's Conspiracy: This case may bring to our notice that a medical education does not ensure an ability to distinguish between organic and psychological illness. Further, it may raise the question as to whether all illness, psychogenic and organic, is a *secondary* phenomenon, secondary to castration phantasy—the phantasy of some injury to sexuality or the symbol of sexuality.

From a philosophical standpoint this may not seem such a curious theory when we reflect that the body itself was caused to come into being and to develop through a sexual process. Anyhow, the clinical facts seem to be that an interference with or an interruption of potency, and a consequent swing of phantasy to castration, commonly carries with it an acute disturbance to the general health, the origin of which may entirely escape the sufferer.

I go further than this, and suspect that every interference with general health (the somatic equivalent of potency) is due to some such castration phantasy, ignored or lost sight of by the sufferer and by orthodox medicine.

In short, ill-health may be nothing more or less than a conversion symptom, with the psychological advantage of diverting attention from the intolerable castration bogey.

This diversion of attention has the advantage to the id of attempting to discharge its pain in a *relatively* tolerable form, namely physical instead of mental. But eventually, while the sexual *concept* is successfully repressed, the *affect* or pain does not escape expression.

Thus, the patient presents himself to the doctor, not with a feeling that *all* is lost (which, incidentally, would cause him to be suicidal) but merely with the complaint that he has a bad leg, an ulcerated stomach, or that this organ or the other is ill.

Medicine seizes this opportunity to enter the conspiracy and to focus its attention upon the diseased organ, with the idea (usually erroneous) that appropriate palliative treatment will restore the organ.

In practice, the minds of patient and doctor are harmlessly occupied with this diversion, while the unseen mechanisms in the unconscious mind sort themselves out, and the intolerable phantasies undergo repression or are superseded by relatively more powerful potency phantasies, the outward and visible result in the latter event being a restoration of health.

CHAPTER XII

HYPPOCHONDRIACAL ILLNESS

To demonstrate that hypochondria, or the type of psychogenic illness that points insistently to physical disease and persuades the medical profession to apply all the remedies not only of medicine, but often of surgery, is not even a clinical entity but may have its basis in a great variety of different causes including psychotic or pre-psychotic conditions and even an admixture of epinous gain motive, I shall proceed to detail a common type of case which has a complicated and not uncommon psychopathology.

Though the term "hypochondria", if used at all, is better reserved for cases where the entire libidinal interest having been withdrawn from environment and society is in its entirety focused upon ideas or delusions of bodily disease—for instance some old bachelors with post-nasal catarrh, or internal troubles and an aptitude for consuming one patent medicine after another—yet this case had been included under this loose term, because, for four years before she had come for psychological investigation, she had spent the greater part of her time under medical and surgical treatment.

Every doctor in the world, whether employed in general practice or in hospital, is only too well acquainted with the type of patient who comes in sad and miserable, and complains of such a conglomeration of symptoms, such a hotch-potch of pain, disabilities and what-not, with such an endless volubility of detail and description, that we are all apt to become dismayed, even perhaps to assume the expression of the patient herself, and finally hope that we, like her, may be released from the intolerable discomfort by an early death!

It was several years ago that this plump, white-faced woman of fifty threaded her way cautiously from the waiting-room to the consulting-room. She obviously felt she was delicate. She spoke slowly and carefully. After all she must be careful even of her voice. She said:

"Doctor, I have had this terrible illness for over four years."

I am afraid it is necessary, even at the risk of tiring the reader, to elucidate the rambling rigmarole of her symptoms, for otherwise it will not be possible to appreciate the main aspect of such cases. After listening to them for half an hour or even several hours, we are, unless we have psychological insight, completely bewildered and no nearer a diagnosis than we were at the beginning.

On the other hand, every problem is perfectly simple if we are presented with the solution. Therefore I defer this solution until our final consideration. It is the only way to describe adequately the problem presented.

She begins by saying: "It started with pains in my feet, terrible pains in my feet. I went to an orthopaedic hospital. After various electric treatments they decided upon a manipulation of my feet under an anaesthetic.

"Doctor, I cannot describe it. After that anaesthetic I could not sleep. It stopped my sleep at once and I have never had a good night since.

"Immediately afterwards started this fear. Two or three months later I had a poisoned gland. I went to the St. X Hospital. They cut it out.

"Then later I went to the nerve specialist. He said it was the result of the change. The pain started in my stomach. I cannot eat anything. They tried all sorts of injections, but I did not get any better. I had an injection on the Thursday, and on Friday I had a shaking feeling all down the right side. Finally, they took me into hospital to be under observation.

"Then they discovered gall-stones and operated on my gall-bladder. I was in there a month. Then they said I would get better . . . but I did not get better.

"Later I saw a doctor who said it was all nerves. I went to a mental hospital. Oh, doctor, what a terrible time I had!

"My present symptoms are that I am frightened out of my life. I have pains. I hardly like to say it, doctor, but I had better. I am afraid I am going to die. The worry of it is driving me mad. It is because I am sure that I have some terrible internal disease which the doctors have failed to discover. Probably it is cancer. I feel so terrified of what it will do to me. Should I commit suicide or just wait for it to kill me? Also, doctor, I am so jealous and spiteful. I do not want my husband out of my sight. I am frightened. I cannot be alone for a minute.

It all seems to originate from here, the chest (but she points to her stomach). I cannot eat. The pains in my head are something terrific. There is also a muddling feeling.

"I lead a very lonely life. My husband had to be away a lot. The doctors have taken a lot of blood from me for high blood pressure.

"My breakdown? Oh, the last straw that caused that was when my husband told me he had taken somebody to the pictures. How long has it all lasted? About four years. It came with this pain in my stomach and then it ran up to my throat. But my head was not muddled at all like it is now. I hated to be in the hospital. I wish I had never gone. Oh, doctor, all sorts of things surge back into my mind!"

Here she starts weeping. Presently she resumes:

"The horrors of the operation and what I have seen! The mental cases . . . good gracious! I shall never recover. . . . I think it will be the end."

This is merely a sample of the sort of complaint which this type of patient pours into our ears for hours on end. But this is no reason why we should throw aside all hope for the future.

On the contrary, it is all the more reason why we should settle down to hear this thing through, for this is the only way in which we may hope to arrive at a diagnosis. It is the only way in which, by understanding the cause and origin of all these troubles, we can ever hope to ameliorate the condition of such patients.

I am afraid the elaborate apparatus provided in hospitals and the temptation which workers have to use them is merely a snare and a delusion for such patients.

I have said that the ratio of time given to listening to a patient's story to that expended in physical examination is an indication of the experience of the physician. In that case psycho-analysts must be the most experienced of all physicians, for they listen interminably and give no examination, whereas the inexperienced, particularly some medical students, cannot be bothered to hear any but the first few sentences of the patient before they rush in with instruments. The precipitate method takes much longer in the end; for instance, this patient had been the victim of such manipulation for the previous four years.

Having related the preliminary interview, I now propose to show how some of the material of subsequent sessions illuminated

this seemingly insoluble problem.

A week or two later she came with a story that her husband had tried to cheer her up by taking her to a cinema. She said:

"The first film was all right. It was only dancing. But the second film called 'Crossroads' . . . oh, doctor! I got terribly bad. I felt I wanted to get up and kill myself. I was frightened. And all these pains came up, all over my head. I tried to banish the thought; but always in my mind it kept coming . . . 'Shall I kill myself? Shall I kill myself?' And all this indigestion!

"I cried a little this morning at the horror of it all. I feel I cannot go on with it. The agony of mind is terrible.

"I am always dreaming of death or dying people. I wake up very depressed and with pain at the back of my head and down my side. The pain is from left to right and all down the right side of my chest down to my stomach, where the operation was. I always want to cry after that.

"And now I am troubled with a fear of myself, as though I shall do myself an injury or go mad. There is a buzzing in my ears and a pain in my feet and it goes right up to my head. I do not know whether it is because I had been worrying."

ANALYST: "What had you been worrying about?"

"I had been worrying about my husband taking that woman to the cinema. I did worry over it. I could not get it out of my mind. Now I have a pain all down my right side. I am always having that pain down my right side since the operation. I think that it started with the worry after my husband told me he had taken that woman to the cinema.

"Doctor, do you think I shall do anything to injure myself?"

ANALYST: "No, I don't think so, because you have already done an injury to yourself."

"It was after that worry about the woman that they gave me my manipulation under the anaesthetic. I have never slept properly since. Two months after that I had the pain in my stomach and that started that fear. I am frightened of myself."

ANALYST: "When did you first hear that your husband had taken this woman out?"

"No, I had no pain before that. I did not want to hurt myself then. It was only when he told me. That was four years ago. I had had a dream and I told him: 'I dreamt I saw you down a quiet lane with a woman.'

"He said: 'That's a funny thing. I took a woman customer'

of mine to the pictures last night.'

"Then he went on to tell me that he took her home and had a cup of tea with her. As soon as he spoke I had a cold feeling come in my stomach as though it were a lump of ice inside me. Then, after, when he went away as usual on the Monday, I had pains. It was the thought I had all those years, almost since we had been married, nearly twenty years. It seemed that all my suspicions were right. All those lonely years of suspicion!"

"My first reaction was that I wanted to make myself look nice so that he would look at *me*. While he was away I had my hair frizzed-up and got a new hat and a new dress. But I was ever so sad. I could not get my face to look nice. I kept trying to get the thought of this woman out of my mind, and I could not. I cannot get it out of my mind yet. Now I feel I want to kill myself. These years of anxiety . . ."

ANALYST: "What would you have liked to have done to this woman?"

"Nothing."

ANALYST: "You are repressing it. It is not yourself you wanted to harm, it is this woman."

"I know I felt jealousy—terrific jealousy. I wanted to see her, but somehow I did not even ask who she was. I seemed to be prostrate with the churning-up feeling inside me."

ANALYST: "Your natural instinct would have been to churn-up the woman: not yourself. The primitive reaction to jealousy is to injure and attack and kill the person of whom you are jealous. You stopped this instinct and kept it inside yourself, and so it churned you up instead, and now it has got to the point when instead of killing the woman you want to kill yourself."

"Doctor, you have used exactly the right words. It churned me up. It has been churning-up my inside for the last four or five years."

ANALYST: "Our instincts are naturally primitive, like those of a wild animal. The wild animal would have rushed at this woman and destroyed for they stood in its path. You would not let it. You held it back. The inexperienced at you and churned you up instead. The 'wild' be bothered to hear primitive instinctive reaction to the situation. Your before they rush : result of this reaction working about inside your body takes much longer

the victim of such perfectly right, doctor. When he told me about

Having related the he had taken to the pictures, I felt I had show how some of the ads of my life."

ANALYST: "What was the film you saw during which you felt so very ill?"

"The name was 'Crossroads'."

ANALYST: "And it was to the pictures that your husband had taken that woman?"

"Yes.

"I think of another instance now. . . . Six months before I became so very bad, my husband took me to the cinema, and when he paid the cashier she touched his hand and he put his other hand over hers. Again I felt that terrible feeling come over me. All my suspicions of him were aroused again. That also was at the cinema.

"It all started long before all this, fifteen years before, when I first found that letter from another woman. It was then—we had only just recently been married—I knew he was carrying on with other women. For all these years I tried to disillusion myself. Somehow I knew it, and would not let myself think.

"Then I had that dream that I told you when he told me about taking that woman out. It was at that point (four years ago) when he told me. I felt immediately: 'I am finished.'

"Then the depression came on, and I got so ill that I have been to all these hospitals and been operated on. I have never been well since. Yes, definitely, I know that that was the start of my illness. I have had so much worry that when he told me that, that was the finish. I knew that life was not worth living any more. I felt that there was nothing more in the world to live for.

"How shall I get rid of this fear, doctor? This terrible fear of myself. It is always the same. It all came over me again when I was looking at that film 'Crossroads'. I felt so terrible. I felt I must get up. I felt I must go to my home. I thought it was the end, and I must kill myself. I have borne it all for too long already . . . the end must come."

ANALYST: "Now, before the end comes, before we ring down the curtain, let us just recapitulate the film, the drama, which you have been writing for the last fifteen or twenty years.

"It begins, soon after your marriage, with your husband's work taking him away from home for the greater part of his time. You are left all alone, brooding. Then, one day during one of his brief sojourns at home, you go through his pockets and you find that letter from an unknown woman calling him 'Darling'."

"I lost all faith, all hope, when I read that letter."

ANALYST: "Week by week, year in, year out, all the time your husband was away from you you nursed the phantasy that he was out with other women."

"Yes, I did. I sat at home and I could think and brood about nothing else."

ANALYST: "After seventeen years of such thinking—and, mind you, this was your main emotional life: you have told me that you got no pleasure from sexual contact—after seventeen years of this, you had this little dream that your husband was down a quiet lane with a woman. (That quiet lane was the vagina.)

"It was a dream tending to confirm your suspicions. You told your husband this dream. He unconsciously interpreted it, and, in order to excuse himself, told you that he had taken a woman to the cinema the previous night. Never mind what he actually told you. What he told your unconscious mind, your suspicions, was simply the truth. All your suspicions came true. You felt the block of ice in your stomach; so life was never the same again.

"But I may add that you had one healthy reaction—and that is going to be your salvation—when you frizzed-up your hair. We shall return to that later.

"That healthy reaction to the drama soon fizzled out. You were disposed to develop this morbidity. Another healthy reaction which was repressed was the impulse to find this woman. However, you put yourself resolutely in front of such a primitive instinct and received the brunt of it within your own body. You put yourself between your instinct and the other woman.

"Immediately you started to get churned-up by these feelings, and churned-up you have been ever since. Not only have you been churned-up by yourself psychologically, but you enlisted the co-operation of doctors, hospitals and everybody you could find to assist you in churning yourself up, even to the extent of getting cut open and taking things out from inside you, of leaving you in pain, ill and suffering.

"Now you feel the drama is moving towards its close. The death that started four years ago is somewhat overdue. In conformity with the drama you fear that you may end it in the appropriate fashion, namely, by killing yourself, like the drama you saw on the films. Don't you see what a lot of nonsense the whole thing is?"

"I see. But my stomach feels terrible."

ANALYST: "Let us return for a moment to that healthy reaction, that frizzing-up of your hair that you mentioned."

"Oh yes, I had my hair dressed up so that I looked nice. I thought when he comes home he will see me looking so nice he will like me better than all the women. He will take me out and make a fuss of me. That was all right for the time being, but, when he went away again, while I was alone, all these feelings came back."

ANALYST: "*You should have travelled with him.*"

"Yes, I should. Because all the time I had an idea that he was carrying on at all the hotels. And you know, doctor, I still think it. Now at last it seems I have lost interest. I seem to have given up all hope. I feel I am only waiting for death."

"Sometimes I think: 'I will try again, I will friz-up my hair. I will see if I can make him look at me like he does at these other women. I will try to feel better. I know that if I do, everything will be saved.' But before long the awful cold feeling in my stomach, that started it all, comes over me again, and I am helpless—a burden to myself and a hopeless worry and expense to my husband."

Psychopathology: Though there is much in this patient's illness which suggests hysterical mechanisms and may justify its inclusion in this section, it is really founded upon a background of paranoia (delusional insanity). Freud has told us that paranoia is founded upon repressed homosexual predisposition, whereas inversion at the Oedipus level is not an essential basis for hysteria. (In my opinion it is not essential in paranoia either.)

Like 33 per cent. of British women, she is not emotionally interested in sexual congress with her husband. She is sexually frigid or anaesthetic. She is *instead* emotionally interested in what other women are experiencing at the hands of her husband.

Jealousy is the watchword of her emotional potentialities. Therefore, all the time her husband is away from her on his travels, she indulges herself in the excitements, tortures and joys of her suspicious imaginings.

The shock of discovering their reality, in even one instance, is too much for her—too much for her capacity to tolerate or control emotional tension. She gets her crisis or "orgasm"—in her stomach, in her head and in every part of her body.

Thus her id, incapable of normal emotions and gratifications,

finds its satisfaction in the feelings, in the "terrific" disturbances, of this illness.

Admittedly, it is a form of gratification which tortures her ego. But that ego was destined to be tortured in any case, for she was from the outset the victim of conflict, a conflict which prevented id-gratification except at the expense of ego opposition.

Nevertheless, what her whole being always wanted was the continuous undivided attention of her husband. Like all women beggarly in their capacity for ordinary emotional gratification, she was greedily possessive of the *symbol* of her gratification.

While she waited in loneliness at home it was only too painfully clear to her that she did not possess *him*. But with the eruption of this illness and its simultaneous id-gratifications, that environmental picture was dramatically changed. Indeed, if nothing else changed it, her success in enlisting hospitals to perform major operations, to put her on their danger lists and so forth, brought the errant husband penitently to her bedside, there to sit and suffer.

I submit that not only her id but her ego itself had obtained a most striking success. By losing her life, by losing the fruitless phantasy of gratification which never matured (the cold block of ice in her stomach), she had gained at least the symbol (*her husband*) of all gratification—if not to her at least to all other women.

This was the morbid position which her illness achieved.

She escaped from her own deficiency and gained instead a symbol of all her fantasied but unachievable desires, the constant watchful allegiance of her husband. At the same time it should not be forgotten that her repressed fury, vengeance and hate impulses had at last in this subtle manner obtained a considerable measure of release.

He was worried. He had to pay, both with the sacrifice of his emotional and physical urges, and with the sacrifice of his time, of his liberty and his purse. At last she had him (where such emotionally incompetent women want their husbands in compensation for their deficiency) right under her thumb.

~~Now what had treatment to offer this woman in compensation for all these dramatic and triumphant achievements? To get well and repeat the experiences of those long lonely years sitting at home with nothing, except the thought of what enjoy-~~

ments the other women were having with her husband? Is she likely to accept such an offer?

This is why all such cases of invalidism are so intractable to all forms of treatment. The illness has an unconscious emotional basis. Sadism has been, through repression, converted into masochism. They more or less enjoy their ills, particularly the occasional crises which they achieve with the co-operation of the medical profession, or more specifically the surgical profession, for masochism naturally arouses sadism in any normal person who comes in contact with it.

If these processes can be rationalised everybody is happy; that is to say everybody except perhaps the patient's poor ego. But this merely serves to remind us how unimportant to such patients is the creation and perpetuation of life.

We, as egos, are still faced with the problem: *Can such a patient be cured?*

The answer is: *Only if she can achieve a resurrection of her emotional pleasure life.*

Analytically this is possible only through the agency of transference. In short, if her earliest infantile emotional attachment to her parents can be revived in her relationship to the analyst, her id may find this a better gratification than the ego-torturing "gratifications" of her illness.

Having re-achieved a happy childhood, she will have a fresh chance of a more successful re-development. In this re-development she will find her husband becomes a necessary agent instead of a mere compensation for the beggarliness of her emotional ineptitude.

In this particular instance, practical necessity demanded that we contented ourselves with only a partial amelioration.

The patient had increasingly long intervals when she found that she "miraculously" threw off her illness and even enjoyed little social outings. Such periods became lengthier and more frequent, but I am afraid that they were still interspersed with lapses into the morbidity to which she had long habituated herself.

CHAPTER XIII

DRUG ADDICTION: MORPHINE

IT may seem strange to include these cases under the general heading of "The Hysterias", particularly as a large proportion of drug addicts are described as "constitutional psychopaths", a term presumably meaning cases of characterological disorder with psychotic trends. Undoubtedly their numbers include certain cases of manic-depressive psychosis, paranoid personalities, homosexuals and true inverters; but the truth is that any person who is sufficiently gravely tormented by internal conflicts and an inability to adapt his needs to those of his environment or of society, may have resource to chemical agents to achieve some alleviation if only temporary.

Even so-called normal persons are subject to very minor forms of what might be called "drug addiction" in their habit of resource to tea, coffee, alcohol, not to mention medicaments and drugs from their chemist or local practitioner. In fact every degree of mental conflict naturally drives its victim to seek relief; and as by far the commonest form of this conflict to reach severe proportions is that which manifests itself in the symptom-formations of hysteria, the drug addicts, with addictions ranging from bromides and barbiturates to alcohol and morphine, which I have encountered in my psychotherapeutic practice, happen to have been for the most part cases of hysteria. Though admittedly some have exhibited other reaction-formations and some have had an admixture (as have all "normal" persons) of psychotic trends, that is my excuse for including the following two cases under the general heading of drug addiction.

A pretty girl of twenty-four stood in the dock at a county police court. She was charged with having been in illegal possession of 50 grains of morphia.

The barrister for the police was addressing the magistrate:

"These people, however much they may have our sympathy, *must* be protected from themselves. We must be cruel to be kind. The firmest and most drastic measures are necessary to put an end to their addiction. It is not only a question of teaching them

to mend their ways, but of breaking their habit and fitting them for life."

Other methods of breaking her habit had previously been attempted by a succession of doctors. Each had placed her in a nursing home and by methods more or less gradual reduced her dosage of the drug. The agonising symptoms of deprivation had finally lessened and she had been discharged, but in each case only, sooner or later, to resume the habit.

None of these methods had included the slightest attempt to discover *why* she had originally taken the drug, nor why she returned to it after each so-called cure. Perhaps the world and its doctors were too busy to bother themselves with such trifles. The very word "psychology" makes many people impatient.

On investigation her history proved to be as follows:

She was the daughter of a rich, middle-aged father and a very young mother. Apart from their disparity of age, her two parents appeared to be in every respect mentally incompatible. These are not irrelevant facts; they will show us that the history of her drug addiction can be traced back at least one generation.

The chief memory of her childhood is that of continuous and violent quarrels between her parents. Her father was an intellectual; her mother young and frivolous and a spendthrift. Disharmony in the home was largely responsible for the mother taking to drink.

This led to further disharmony. The outraged father would beat her. She would scream and threaten to bring the child down from bed, infuriating him with her gibe, "She, at least, loves me better than you."

She says: "Sometimes I was brought down, but in any case I would be listening to it all on the stairs."

It is difficult for the average person to appreciate what a devastating effect quarrels between its parents can have upon a child. Stability and the sense of security in childhood depend fundamentally upon its love for both parents. If the parents are always quarrelling its allegiance is, as it were, split; it is as if two parts of the child itself were already at war with each other.

Thus this patient's mind had in a sense been split into two opposing camps even from infancy. But more and more tragic events were soon to crowd in upon one another. She had barely reached the age of puberty—a time when internal stresses alone

are quite sufficient to preoccupy the growing mind—when her mother ran away with a man.

Her most vivid memory is that of her father rushing into the house with a revolver and shouting with much abuse that he would shoot that — woman (her mother). The state of the child's mind as she saw him running down the street flourishing this weapon was indescribable. The seeds of neurosis already sown were certainly being well watered, and more was to follow.

The embittered father apparently vented his hatred for the mother upon this portion of her left with him, namely the daughter. It seems that his mind must to some extent have been unhinged, for he treated the child brutally and kept her up late at night to do so. A couple of years later he died and she then lived with her mother and stepfather.

If we could have looked into her mind even at that time, we would have detected the most utter confusion, torment and distress. The parents are the whole universe to the growing child, and throughout her life this had been a universe of utter chaos; chaos within her mind was the inevitable consequence.

However, there was plenty of drink about the house in keeping with her mother's tastes and she was barely sixteen when she found an alleviation of her mental conflict by surreptitiously helping herself to liquor. The example of her mother was at least an encouragement in this respect. Thus she became an addict, albeit only to alcohol, before she had reached the age of eighteen.

The very frequent headaches from which she was suffering at that time she says preceded the drinking habit. Whether that is true or not, attacks of acute facial neuralgia, and in due course frequent abdominal pains, soon followed in their train.

Either mother did not love the child, or was in too much of a muddle with her own mental condition to bother about her. Whatever the cause, she was only just twenty-one when she was taken to Paris by an older lady of foreign extraction. It seems that there she fell into bad hands, and though we need not go into her harrowing experiences it is sufficient to mention that they resulted in an abhorrence of all males.

An operation for appendicitis was the next event. I have seen so many neurotics who have been operated upon for alleged appendicitis at the critical stage of their psychogenic illness that I am inclined to regard the history of this operation as almost

adjusted I do not know how they can expect me to make a cure simply by forcing me to give it up. Whether they force it by imprisonment or any other way, I know I should only go back to it at the first opportunity."

When pinned down to her remark that she realises why she is taking the drug and asked to give the reasons, she hesitated a great deal and then gave only superficial and quite unconvincing "reasons".

She said: "First of all it is the fact that I have not enough money to do what I want to do," and then: "Life never works out as I want it to."

Finally she said: "Anyway, I think it is life altogether. As soon as there is any responsibility or any call is made upon me to cope with anything, I am quite helpless and must have the drug. As you know, I started taking it for neuralgia. Now that I have experienced how it takes away all my mental pains, I would take it for anything and everything, for life itself."

Further analytical investigation shows that these "reasons" which she adduces are very far from adequate. She says: "When you tell me to talk about what is in my mind, I can only tell you that there is nothing in my mind, there never is. I never sit down and rest and think, *I do my best to avoid that.*"

"I read all the time that I am not sleeping. I do not see any point in thinking of my troubles because it only gets me in an awful state. I do not want any help from anybody. It does not help me to sit and think or to discuss anything that is in my mind. Besides, it is an effort to talk. I rarely talk; it is much less effort for me to listen or to read."

I then suggested to the patient that she should not bother to talk but should just lie there in silence.

Presently I ask her if she is feeling quite comfortable. She says: "I must admit that I am mentally most uncomfortable lying here silent. The very idea of psycho-analysis makes me nervy. It is because in anticipating it I have thought that nothing would come into my mind. I have been in a terrible state of anxiety about it and being shut up here with you in this room is most nerve-racking, and though I quite liked you at first sight, I do not think I shall ever be able to stand it. That is why I took an extra big dose just before coming in, but I am still most uncomfortable with you here. You see, I simply have to drug myself."

At this point I suggested to the patient that perhaps she ought to drug *me* instead of herself, in which case I would be unconscious in the room and she could feel quite at ease and free from all anxiety!

This brings us to the question as to *what* it is that this drug addict must drug. The answer would be the same if we asked the question what is it that she must always avoid coming into her thoughts. It is on account of this that she can never rest and think.

When she says "I am frightened of this treatment because I always thought that *nothing* would come into my mind", she is making the usual mistake. What she is frightened of is the *something* that might come into her mind, and it is a fear of this something which results in nothing coming into her mind.

Now what is this something, what is this "monster" that she must drug lest it should come to life? What is this "monster" which the analyst symbolises by his presence and which is responsible for her state of anxiety, an anxiety which at times she fears she will not be able to cover up by the usual irrelevant words?

We may reply that it is something which might be called "life itself", but that does not tell us enough. It is the something with which she is afraid of coming into contact. The drug helps to alleviate that anxiety. The drug is a sort of "cure" for life itself, a deadening of it if not a complete extinction. But I must try to be a little more explicit than by just calling it "life".

She has told us that as early as sixteen she took to drink, but this was not the ideal remedy; though it deadened something it also tended to liven up something else. The drug had not the latter disadvantage.

This is an attractive girl of twenty-four; attractive to the opposite sex. But from her earliest memories (contact with them beginning with her father) the treatment she had received from men had not been calculated to allay anxiety. On the contrary, kindness, security and protection had never been offered her. The approach had been such as to cause her developing love tendencies to retreat in alarm and horror.

Of recent years she has called herself homosexual. I think the word "homo", when used in this connection by persons fairly obviously designed to be heterosexual, might be translated as "little" or "lesser" sexuality—something short of sexuality, and

of course far short of it in its satisfactions, sexual and psychical and real.

The ego speaks of "life", she is afraid of "life", but to the id and the deeper levels of the unconscious mind life is instinct, the demands are instinct, particularly sexuality. This is the "monster" that she has to drug to keep it sleeping. All other adjustments would have to be subsidiary to life's demands. She cannot even begin them.

This brings us to the question of cure. I am often asked whether I cure my patients. Not the least of the objects of these case sheets is to get the readers to reorientate their minds of this conception of cure.

I am reminded of a man who turned up at the surgical outpatient department of the hospital where I was a student and asked the surgeon to perform upon him the operation of double orchidectomy. When asked why he wished for this to be done seeing that the organs were in healthy condition, he replied: "I have tried every other cure and I now know that this is the only one that would be effective."

"The only cure for life is death." We are all victims of a "disease" called "life" which makes us restless and forces us into certain activities calculated to relieve the restlessness or to gratify the instincts. However complicated these activities may become, they are serving these essential instinct purposes, including perpetuation of the species.

There is no cure for this state of affairs other than that of accepting our position and obeying nature's demands. But this is never fully successful. Death is the only complete "cure".

This patient had found a workable compromise between life and death, between a refusal to accept her fundamental nature and follow the destiny assigned to her on the one hand and complete refusal by death on the other hand. The drug deadened something, perhaps everything, that mattered, and she can just go on living, as it were at half-mast, in the course of a fairly short journey between life and death.

Did I cure this patient? The answer is "No". She had already found for herself a "cure" which enabled her to refuse life. She did not want to be honest or straightforward, she found it all too anxiety-provoking. She preferred the clouding of her mind, she preferred not to think, in order to avoid anxiety or a consciousness of the life urges within her.

She did not even give me the opportunity to unravel the details of her conflict, leave alone to alleviate it. Analysis, like life itself, was to her too anxiety-provoking. It might have brought to consciousness all those terrible but successfully repressed heterosexual urges, the "monster" that she was keeping drugged.

This diagnosis is to some extent borne out by her behaviour. In conversation with a friend who had been analysed, she discovered that a phase of analysis arrives when the patient is dependent upon the visits to the analyst.

She expostulated with horror: "Why, I would only be giving up my dependence upon the drug in order to become dependent upon a man. It seems one has to be dependent on something or somebody, and if that is the case I would rather it were my drug. I know my dosage there and it keeps me quiet. I want none of your emotional disturbances, thank you!"

Is this cure or illness!

And what about her brothers and sisters of all ages; the hundreds of thousands, the millions of people who fill every doctor's waiting-room to receive their weekly ration of bromide, barbiturate, salicylate, codeine or other opium derivative or equivalent! One and all they are like this patient more or less dependent upon the drug or the doctor to still the life within that gives them discomfort instead of comfort, pain instead of pleasure. Might they not be better taught to resolve their conflicts in favour of living instead of persistently and fruitlessly trying to "deal" with them by drug asphyxiation, a modicum of protracted death! But dealing out minute doses of "death" to the hosts of world addicts is the quick and easy task of pharmaceutical medicine, and to turn attention from medicine to mind what doctor has time, interest or ability?

CHAPTER XIV

DRUG ADDICTION: ALCOHOL

LET us turn to a case where the trouble may have been similar though the outcome strikingly different.

The last case was rather characteristic of cases of drug addiction, in that the patient absented herself from treatment almost before it had begun, and certainly before the analyst had any opportunity to fathom her psychopathology, or to help her to a better adjustment to life.

The present patient, unlike most sufferers from addiction, continued treatment long enough to lead to an almost exciting understanding of the psychopathology of this habit. The addiction was not so serious as that to morphia, cocaine or similar drugs. Perhaps the morbid condition that the chemical was alleviating was not so pathological.

I feel that in some cases of drug addiction the patient is only succeeding in avoiding a psychosis by the deadening effect of the drug, so that some doctors and magistrates, with all their good intentions of removing the poison by hook or by crook, may thereby be removing from the patient the only alternative he or she has to insanity.

In this case the drug was of a milder, less toxic nature, indeed one in which a vast proportion of human beings find refuge, and perhaps for the same reason as this patient found it, namely to mitigate the discomfort of a common unconscious conflict.

This is the classical conflict between id and super-ego, between the urges of the basic selfish, pleasure-seeking instincts on the one hand, and the repressing forces of authoritative super-ego or conscience on the other hand. Are we not all subject to this conflict in varying degrees, and do not a considerable number of us therefore turn to alcohol for temporary or periodic relief?

The patient is a man in the early thirties, who has burdened himself not only with business responsibilities, but also with an excess of voluntary duties in connection with war service.

He has, indeed, achieved a very high position in the A.R.P., while retaining the directorship of his business. He is in a rush

of work from dawn till dusk, almost tumbling over himself with over-hurried activities, and this is all the more remarkable in that he is usually semi-intoxicated.

The impression created at his first interview, and the subsequent ones, is that, however brilliant he may have been, at present he certainly has no time to think. This is the key to the situation: on no account must he give himself time or mental ability to think. The agony would be too much.

It was merely because his methods of defence against thinking, namely, the *flight into activity*, were beginning to fail in their hitherto remarkable success, that he was reduced to coming for treatment. Tumbling over himself mentally, he had finally begun even to tumble over his realities, and therefore something had to be done.

He said: "I am getting into trouble with myself. I am drinking too much. In the morning I can't think till I have had a large Scotch. I feel I have got to have a large Scotch before I am any good. Then I seem to lose all control; I have a second and a third. My work is technical work: God knows what is happening to it! I seem to get far too impetuous. I rush at everything. I keep doing contrary things; rushing to work, stopping on the way, and then not going at all.

"The truth is, I am getting a bit frightened of this drinking business, doctor. I am afraid my wife, with all her good intentions, does not help me at all. She keeps telling me not to drink, and thereby reminding me that I want a drink. My father is one of those confirmed teetotallers, and therefore I get the feeling that I am committing a crime. But it doesn't stop me from committing another, and another.

"As a younger man, before I married and left home, I remember seeing my father's car outside when I had come out of a pub, and literally I jumped as though I had been caught at a crime. Now I feel like that towards my wife. So I drink surreptitiously, hoping that she won't catch me—stop at the pub on my way home and pretend I haven't. The more I have the more I want."

Analyst: "The amount?"

"Well, I suppose one might reckon it at about twenty shillings a day."

Analyst: "Family history?"

"Good Lord! They are all teetotallers. Oh, no! There is one

case, only one, a second cousin. He is a confirmed inebriate."

ANALYST: "*Is there anything in your life from which you want to escape?*"

"I can't think of anything . . . unless it was as a boy that I wanted to escape from father and mother. And now it seems that it is my wife that I want to escape from. But what I am saying is quite misleading. The opposite is the case.

"As a boy I always wanted to do as mother and father wished. I had a 'conscience' if I didn't. And now I want to do as my wife wishes. I am a good, loyal husband . . . I hope. It isn't her, it's the drink I want to escape from. I want her to help me, only she doesn't . . . makes it worse.

"My home life was happy. I was an only child—very much the son of my parents. It was all rules and regulations—father's orders, and I kept them . . . mostly. I did escape from that in the end, and got married, and now it is the same old thing all over again, and my wife in the rôle they were in. I escape to the pub.

"I had a dream the other night, or rather two dreams. In the first I was in an underground office, in the basement of a very tall building. The walls were all green. A breeze partition was being put up. My mother and father were going to occupy one side and my office was going to be on the other. The trouble was that they had nearly all the room, and my office was crowded into a sort of curved passage-way. I had the worst part, and, besides, the partition was never finished.

"In the second dream there were women—one particularly attractive woman. I think she was the mayor's daughter, only he hasn't actually got one. Suddenly my mother came on the scene and said this woman was a dreadful reprobate; if only I knew the kind she was I would not have anything more to do with her.

"Doctor, this reminds me that the first time I took my present wife home, my mother was in an awful state, and said she was not a suitable person for me. She kicked up an awful row, but, surprising to relate, my father took my side.

"My mother's attitude worried me, and the next day I went home alone, but drunk. It was because my mother had been so cruel. Anyhow, this time it was my father who was cruel. He gave me 'what for' for stopping at pubs and getting drunk. He went further than this, and made me promise to give up flying.

"All the flying people got drunk. Flying had been my only excitement up to the age of thirty. I had not gone in much for girls or anything else. I was known at the air-field as the 'Crazy Hedge-hopper'. But it was a good escape from the very strict household I was brought up in. . . .

"The flying people were largely one type, perhaps my type. Racing, gambling and drinking, but, curiously enough, usually no women. We had those parties, but I can't remember any sex in the debauchery. It ruined my exams. I had done quite well until that third year of my university career when I got this craze for flying. That is when the drinking started.

"Later I got married to this same woman that my mother had rowed about. And now she is as bad, or as good, as they were.

"She was passionate enough, I thought, before marriage. But now she is not interested.

"I have lost my flying friends, but I go to the pub and drink on my own . . . that is to say when I am not attending all these A.R.P. meetings and war-work duties that take up almost every minute of my spare time.

"A curious incident happened last night. I was going off to an important A.R.P. council meeting in Whitehall. I got a bit late. I stalled the engine of the car, and could not get it to work again until it was too late. In fact, I met one or two people coming back from the meeting. And, do you know, instead of feeling annoyed with myself, I felt an enormous sense of relief.

"I went off to the pub and had another drink, and felt like a schoolboy on holiday. I felt, 'Thank God! Be damned to them all! I am me!' and for the first time that day life was good. Isn't that extraordinary? What does it mean?

"When I got home my wife suggested that we should go to bed together. This surprised me, as usually that is my tendency, and hers is the reverse. But because she suggested it, I refused. Why should sex happen only when she chooses? That night I dreamt I was connecting up two telephone circuits."

ANALYST: "*Free association of thought?*"

"No. I don't think that has got anything to do with sex.

"There was another dream. I was driving my car up a hill and the wireless in the car was playing loudly. I knew it was illegal, but I could not turn it off. I was approaching some people and I wondered what would happen. Apparently I had

put an aerial underneath the car so that it would not be seen."

ANALYST: "Free association of thought?"

"It reminds me of the criminality feeling when I have a drink. That was pumped into me for several years before I married.

"I dreamt also that I was dismissed from the A.R.P."

Psychopathology: So the material of this case goes on and on. We listen to it daily for many weeks. Here space has permitted me to give only an excerpt. The conclusions force themselves upon us cumulatively as the material increases in abundance.

The patient is the victim of a very severe conflict between, on the one hand, his id, his primitive pleasure-drives, his self-satisfactions and his self-expression, and, on the other hand, over-strict parental morality and discipline, this latter being now replaced by what one might call an uncomfortable conscience.

The first dream he gave us shows topographically the condition within his mind. There he himself (his office) is crowded into a small space, a passage, by the excessive room occupied by his parents. It is noteworthy that the breeze partition between has never been completed. Thus we see within his mind the uncomfortable juxtaposition of himself, of what he would like to do for pleasure's sake, and the obstructing influence of his super-ego formed out of parental influence.

How can he live comfortably in such quarters?

The green colour of the walls is directly associated with the interior decoration of the junior school which he attended, revealing that the condition dates back to that period. The whole interior might, at a deeper level, be regarded as a womb symbol. He has never comfortably come out of it, come out of the restrictions and restraints of his parental upbringing.

In the second dream an attempt is made. There are women, particularly one woman, but here the conflict with the parent-formed super-ego becomes apparent and dramatised in his mother's denunciation of the woman. Life is not different from dreams. When that happened in real life he apparently dropped the woman and got drunk. The drama of his real life before marriage was similar to this. He did not have women or sex as a rule. Conflict with the parents and/or with conscience would have been too great to permit of such behaviour.

Drink was a lesser crime, a lesser indulgence of his primitive urges and need for gratifying himself in spite of or against his

parents. Besides, drink had an additional advantage in that its chemical influence dulled the anxiety, and, as it were, gave him Dutch courage to enter the battle against these repressing forces.

There is much evidence in the material he produces that drink is a sort of defiance, ammunition for his id or primitive self whereby he vanquishes his parents. It is said that alcohol "deadens" the conscience. Thereby he is free at last to escape from this parental or conscience prison, and for a moment, as it were, to be himself.

But it is only for a moment. Immediately afterwards the reaction sets in. He dreams that he is dismissed from the A.R.P.—driven from the love and home of his parents. Therefore he must rush in to more and more parental service to win back their love.

He burdens himself with many duties. He rushes off in his car to more meetings, however much his heart may hate them. But on the way his car stalls and will not re-start. He has escaped the domination of these adults, and is free again to have another drink and to indulge himself.

Thus we see him rushing hither and thither, forced by conscience or super-ego to a suppression of himself, the would-be naughty boy, until revolt starts in the naughty boy and he wishes to kill these parents. But he cannot do it without anxiety.

So his method of doing it has an advantage over all other methods for it includes a chemical (alcohol) which allays anxiety, produces Dutch courage, and enables the naughty little boy (very little) to defy these great monsters—parents and conscience. So he comes into his own temporarily, only to reverse the process in the next phase.

The symbolism of his car-driving dream is obvious to any psycho-analyst. The wireless playing loudly symbolises the emotional exuberance of sexuality. He knew it was illegal, that is to say contrary to parental orders, but he could not turn it off. But he was approaching some people, and what would happen? In spite of his attempts to conceal these practices, his "criminality" would be discovered.

It is not without interest that his own free association is not sexuality but "drink". He says "criminality feelings when I have had a drink—that was pumped into me for several years by my parents".

His drinking is largely a symbolical substitute for his re-

pressed and unconscious sexual impulses. He is doing it instead of indulging in sexuality. It is not so big a crime; it is less offensive to the parents, or rather, to their successor, within his mind—his super-ego.

Thus we see the drug, alcohol, as an adjunct to the playing-out of a fundamental psychoneurotic conflict. While expressing one side of his conflict in the defiant act of drinking, he is at the same time trying to bolster up his otherwise timid self-indulgence by the chemical aid of the drug. The demands of parent-equivalents, such as reality, *will* intrude nevertheless. Perhaps the system only fails because he cannot remain totally inebriated all the time.

A revelation of this unconscious battle and the part his drinking compulsion was playing in it gradually began to have some effect. But it was not until after he had discovered his tendency to place the analyst in the original parental rôle that the source of the conflict was impressively and effectively brought home to him.

He went through a phase when he resorted to drinking rather than punctuality at the sessions and in several ways played out the drama of his Oedipus anxiety with the analyst in the rôle of the stern and frightening father imago.

In the last analysis it was revealed that drinking symbolised a defiance of the all-repressive father, an emergence and resurrection of his all but destroyed id, a gratification of this id by free indulgence in the prohibited incestuous act—only this desire had regressed so far that it now took the form of a breast (drinking act instead of a genital one)—and at the same time an increased anxiety regarding what “father” would do to him, an anxiety which in turn could be allayed only by more drink.

Thus we see that his drinking behaviour, as well as his dutiful over-exertions, were very strongly *over-determined*, but there was even more over-determination than this; it transpired that at the same time, his chief concern being with the terrifying father imago, he was partly yielding, surrendering sexually, to him. (repressed homosexuality), and partly resisting this surrender and trying to dull the anxiety of the resulting conflict with still more drink. Thus we see that this excessive drinking, like all psychoneurotic symptoms, was a method of “dealing”, not of course with realities, but with the world of deep, unconscious, primitive, dramatic and terrifying phantasies. It was the one

act that dealt simultaneously with all aspects of the unconscious struggle. Its over-determination was the cause of its strength and persistence; and, as these phantasies came vividly into consciousness through the interpretation of their evidence in the transference, their power to provoke anxiety and their compulsion over him diminished.

Not only did his relationship to the analyst improve, but that to his wife underwent a radical change. She too became a consolation instead of an anxiety, and discord gave place to domestic felicity.

There was no longer any need for excesses in "dutiful" exertions, nor for excesses in alcoholic indulgence.

Sanity reigned in place of neurotic compulsion, sobriety in place of drunkenness. If you met him now you would not suspect that he was once fairly on the way to acquiring a permanently red nose.

CHAPTER XV

HYSTERIA, ANXIETY AND FEAR OF EPILEPSY

BEFORE concluding this Section on the rather heterogeneous group of cases which I have grouped under the general term "The Hysterias", I would like to add another which may help to give us a glimpse into the fact that psychoneuroses in general and hysterias in particular have two important aetiological factors: firstly, a source of dynamic energy (the energy which activates the symptoms) in undischarged or inadequately discharged psychosexual tension; and secondly, a psychological nucleus in the Oedipus complex. This latter may be detected in the form of a parent-fixation.

The following case, though not as dramatic as some of those preceding it, may serve to remind us of the very close relationship of anxiety neurosis and hysteria, and to suggest a possible connection or transition not only from the former to the latter but also from psychoneuroses to at least some forms of epilepsy—the subject of the next chapter.

THE CASE.—A capable and healthy-looking man of forty is sent to me by his doctor because, after twelve months of struggle, he has been invalidated from his work as manager of a munition factory.

His illness began with periodic attacks of blindness, but in the foreground of the picture there is the familiar symptom of impending collapse.

"As soon as I enter the workrooms I feel unsteady. A sort of giddiness or faintness comes over me. My legs feel funny and I have the impression that I am going to fall. I have to hold on to something to support myself."

"It has got worse and worse until finally I have had to give up work. Even that has not led to much improvement for I am now so bad that the symptoms come on whenever I stand up. It would be quite impossible for me to go to a shop or to stand in a queue anywhere."

Other symptoms include those characteristic of what is called an "anxiety state", or, in popular language, "nervous breakdown". He suffers from extreme irritability, hot and cold feelings, headaches, palpitation, attacks of shortness of breath, and depression.

Nevertheless this man had at the onset of his illness been sent by his doctor to a succession of specialists. Presumably on account of the initial eye symptoms, he was first sent to an oculist. This gentleman suspected inflammation of the optic nerve with retrobulbar neuritis and passed him on to a specialist in organic nervous diseases. To the credit of the latter it must be said that he could find no sign of any disease.

Nevertheless, as it is the doctor's business to discover the cause of symptoms and to establish a diagnosis, he was in due course sent to a third specialist. To cut a long story short, the patient was shuttle-cocked from one to another with alternating diagnoses of disease and no disease.

Eventually he was fortunate enough to find a doctor who, having listened to his story, refused even to examine him and succeeded in convincing him and his medical practitioner that the condition was purely of psychological origin and that psychotherapy was the only appropriate treatment.

Much time and trouble had been wasted and the patient had in the course of these twelve months suffered greatly and become considerably worse. I am relating this story as it is all too familiar.

Starting with the handicap of highly strung, moody and nervous parents and also with the handicap of being an only child, this patient had suffered even in infancy from night terrors and nervousness. His mother had given him her whole attention while his father had endeavoured to balance this by over-strictness.

In due course it transpired that throughout his childhood and adolescence he had experienced a succession of minor nervous disorders almost amounting to breakdowns.

At puberty he had had his first definite nervous breakdown. He was already working in a factory and one of his workmates suffered from epileptic fits. He developed a phobia of these accompanied by symptoms similar to those of which he now complains.

He felt then, as now, that his legs would give way and that

he would involuntarily fall and lose control of himself. He even went so far as to fall on more than one occasion, but he says the terror of it was worse than the experience.

"I was too scared to work in the same room as this boy. I had the feeling that I was going off my head. I felt convinced that I was going to get epileptic fits the same as he had."

ANALYST: "*And did you?*"

"No, I only got nervous and sleepless at night. That was at the age of fifteen."

ANALYST: "*What was it you were trying to stop at the age of fifteen?*"

"I don't know."

ANALYST: "*Epileptic fits?*"

After a brief silence the patient, who is exceptionally intelligent, said: "Do you mean sex, doctor? I know that boys at that age abuse themselves, but if I had ever done anything of that sort I had always succeeded in stopping it in time. But I don't think while that scare was on that I was doing anything of that sort. At that time I was interested in one thing only, that is in these epileptic fits."

ANALYST: "*What is the association of thought to the scare of epileptic fits?*"

"The fear of losing control of oneself."

ANALYST: "*Do you commonly lose control of yourself?*"

"Only since I have developed these symptoms. I have always prided myself on my perfect control and 100 per cent. efficiency. I have worked very hard and been most successful. That is why it is particularly humiliating to me that this illness should interfere, as it does, so completely with my ability to control myself."

ANALYST: "*I understand that your engagement lasted ten years. Was that a sample of your control?*"

"Well, though I had some nervous breakdowns during that time, this one has come on after five years of marriage."

ANALYST: "*Does the control persist within your married life?*"

"I have read something about the subject and I understand that one's wife's requirements should be considered first. In that respect only do I control myself. Of course we do not want any children and she is against the use of contraceptives. Naturally, this necessitates some control on my part."

After a considerable silence this intelligent patient expressed his thought: "You do not mean to tell me, doctor, that the epileptic fits I feared and the loss of control and collapse which

I now fear are nothing more or less than a substitute for the climax of the sexual feeling, which at fifteen and lately I have been preventing from taking place?"

This was only the twelfth session and no reply was given to his question, but he apparently answered it himself in the affirmative, for he said:

"If you had told me anything like this when first I came to see you I would have rejected it completely. Or even if I had heard you and told myself that I must believe what I was told by an authority, it would have made no real impression upon me. But now I seem to feel that it certainly had something to do with my breakdown at the age of fifteen and my fear of those epileptic fits. It is an amazing revelation to me."

The very next evening the patient presented himself as an altered man. These are his actual words:

"Today I felt very much better, better than I have felt for twelve months, and my depression has gone. I feel much happier in myself. It cannot be an accident that I feel better, but if you ask me why, I cannot tell you.

"Two or three weeks ago quite candidly I felt it would not have mattered if I did not live any longer, but I would not like to die now. Yesterday I read a most detailed report of something that I could not have looked at a few weeks ago and I read it with interest. I have not smoked for weeks, but today I put on a cigarette. I have now lost the blurring vision in the left eye which was the first thing that brought me to the doctor. Even then it was only with the severe attacks that the blurring used to come on. But for some time I have never been entirely without it. I have not had it at all today. For periods of half an hour at a time I have had none of the usual sensations. This is quite a novel experience for me."

ANALYST: "What do you attribute it to?"

"Our conversation last night. Up to last night I was wholly ignorant of what my symptoms were all about and of the gist of the treatment. But last night I got the idea of free association of thought."

(What he means is that through free association of thought he made discoveries which would have been meaningless to him if arrived at by any other means.)

"I can see how one thing balances another. When first you seemed to put to me the association of the sex question and

epileptic fits I thought that ridiculous. But later on I saw it like somebody sees religion. Before that I was trying to fight my feelings as though my life depended upon it. But now I understand them and it does not worry me and my depression is gone."

Such complete alleviation of the symptoms all within twenty-four hours must be more apparent than real. The psychotherapist should not, like the patient, be the victim of wishful thinking, and therefore I was not so pleased as he was at this very sudden and complete change in the picture.

I suspected that some phantasied conquering of his illness had come about and had temporarily created the illusion of cure.

Quite innocently he confirmed this impression by relating to me the dream of that very night. It is worth recording not only for this reason, but because it is such an excellent symbolical representation of the three main topographical levels of the human mind. Each is represented by a person. The dream:

"I was an officer and was accompanying an Air Marshal to arrest a man whom I know but have not seen for several years. This man was a friendly but unstable sort of fellow, always up to pranks and frequently drunk. The Air Marshal and I were immaculately dressed, most dapper and smart. We had revolvers hanging on us.

"As this chap was dangerous I held my revolver in my hand to keep him covered. He was behind a curtain with a light. I called upon him to surrender, keeping my revolver pointed at him. My order was most peremptory.

"After I had called several times, he came out from behind the curtain. He wore a silk hat and had on a magician's cloak, but I knew that one of his legs was missing. His face looked distorted. He looked very dejected and said: 'I will come quietly.' "

The patient, who is completely innocent of the significance of dreams, naturally disregards it and continues: "Feeling better today was like being reborn. When I did once or twice get the bad feeling I consoled myself with the thought, 'Oh, this is nothing, just an outlet for something else that is wrong.' "

ANALYST: "*What was wrong?*"

"When I was a boy of fifteen, the improper sex life I had at that time. I associated it with the man with the epilepsy which had really nothing to do with it. While I persistently thought it had no connection when you first mentioned it, on reflection I

was surprised that I had not seen it. Whereas before I thought I would never be cured, now I can see the light dawning on me."

(Silence.)

ANALYST: "*What are you thinking about?*"

"I was thinking of that man in the dream . . . one of his legs had gone—the left leg. I would expect him to hop about or drop to the ground."

ANALYST: "*Drop to the ground?*"

"Well, of course, it is like my fear of falling."

ANALYST: "*How had he lost his leg?*"

"The thought in my mind was that he had lost it through the silliness of the things he had done."

ANALYST: "*What silliness have you done?*"

"As a boy abusing myself and holding it back. I just felt that I must hold it back."

ANALYST: "*But you would not expect to lose a leg by that?*"

"I might have expected to lose my reason."

ANALYST. "*Hence your fear of mad people and of epilepsy.*"

"Or I might expect to lose the organ"

ANALYST: "*But in the dream the man had lost a leg and in your symptoms you fall or fear falling*"

"But now I feel I can control myself better. I have had to control myself in many respects. I have controlled my sex life too. Firstly, for most of my life on account of my parents, for their sakes, and now for the sake of my wife. I have done a lot not to cause any worry or anxiety to my parents and I have always felt that it was more important to please my wife than myself."

There were only two things that puzzled me in this dream, and so I asked the patient for his free associations of thought to them: the magician's cloak and the top-hat.

He says, "covering up a defect" (lost leg), and he adds, "also he wore a top-hat to create an atmosphere".

It is worth noting that it was the *left* (*i.e.* not right, *i.e.* "wrong") leg which the dream-figure had lost, that the patient unconsciously "castrated", fears that his *left* leg will give way and cause him to fall and that it was in his *left* eye that he suffered from blurred vision. The top-hat is an attempted restitution of the castrated organ.

The rest of the dream is easy to interpret. All the figures are

elements of his own psyche. He himself symbolises his ego or conscious mind.

The high officer, Air Marshal, stands for his super-ego, or contribution of parent-figures and authorities, while the interesting character which these two have set out to arrest is nothing more or less than his id or primitive, animal, instinct-level self which enjoys being on the loose, cutting capers and generally being completely out of order.

The contrast in dress between the immaculate uniforms of the ego and super-ego and the ridiculous get-up of the id speaks for itself. The former two are the embodiment of discipline and control, the last symbolises the waywardness of emotion with its pleasures and sufferings and its conflict between potency and castration.

In his dream he, his ego and super-ego, have symbolically arrested the delinquent and so brought him under their disciplinary control. In consequence he feels that everything has been put right; control wins the day and he has his illusionary cure.. Unfortunately, or fortunately, there is no id which is so easily mastered by super-ego and ego forces.

As I have said, this dream was a symbolical representation of what was taking place or had that night taken place within the patient's own psyche. The following dream, given at a later session, is an equally apt picture of what was taking place in the patient's domestic environment and, of course, having its repercussions upon his psyche:

"I was in a room with my mother's sister and my wife. My wife got up to sing; she sang very well and I was enjoying it immensely. Half-way through the song she was interrupted by my mother's sister also singing. The interruption stopped my wife completely and I got very annoyed about it. There was a row.

"My mother's mother came in and sided with me. Then another female relative of my mother's took up the challenge on my aunt's side and said I should be quite satisfied with what had happened. This relation of my mother's owed me money and I made a wisecrack retort by saying, 'It is about time *you* gave *me* satisfaction.' That was the end of the dream."

This dream will be better understood if it is mentioned that this man of over forty has brought his wife to live with him in his mother's and father's home. In this home he is the master, his mother is a close second in the management of affairs, his

wife a rather poor third and his father a nonentity.

In keeping with this it is noteworthy that the father is not represented at all in the dream, but the other three members of the household are each represented, the mother three times, though each time disguised as a close female relative.

Singing is love-making. The patient immediately associated the pleasure of listening to his wife's singing in the dream with the pleasure of sexual intercourse. But without going to such a deep level as that, the dream tells us the significance of these persons in the emotional life of the patient.

After all, he had his mother and lived with her as the only child for nearly forty years before his wife came into the picture. It was his mother who "sang" to him or loved him for all those years. She gratified all his needs—with one notable exception. It is this failure on her part which has finally driven him to break his lifelong "loyalty" by bringing in an "alien" woman as his wife.

Considering the odds against her, this wife is getting on very well. She is singing and he is enjoying it. Then the mother, camouflaged as her sister, takes a hand, evidently to woo back her son. This stops the wife and annoys the patient.

But mother has many parts. A part of her, represented as the grandmother, sides with him against that emotional element in her which interfered with the wife's love-making. In this connection the patient says:

"There was a terrible row at home when I told them of my engagement. There is no describing the scenes we had. I nearly had a nervous breakdown at that time. But finally mother gave in and accepted my wife as though she were a daughter."

Thus in the dream we see the various elements in the mother alternately interfering with and supporting the love relationship of the wife and her son. A point is that this is the *patient's* dream and all these influences are variously felt, deeply and largely unconsciously, within his own psyche.

What he is perhaps least conscious of is that the "marriage to his mother" which began at his birth has never really been dissolved. The only child had received all benefits at her hands, and was justifiably expectant that all his growing needs would be similarly adequately gratified. The one exception was his maturing sexual need. When she denies him a wife, or interrupts the latter's "singing", no wonder his outraged *id* turns upon her

with the retort, "It is about time *you* gave *me* satisfaction."

To explain how a married man with a mother-fixation, even in spite of an apparently satisfactory married life, can be suffering from unrelieved or unrelievable nervous tensions resulting in a state of nerves with irritability and anxiety, I cannot do better than quote a subsequent session with the patient.

He began with these words:

"Yesterday was a particularly good day, but today has not been so good. I have been languid and worn-out and yet feeling a certain amount of nervous tension. I had an extraordinary dream last night.

"It was about an aunt of mine who has been ill with nervous trouble similar to mine. I said to her, 'I will treat you.' Apparently I was a physician. The room was like this and she lay down on a settee like this in the same position as I am in here. I was behind her as you are behind me. I asked her about her symptoms and while doing so I was massaging her head. And, this is the extraordinary thing, although she is nearly seventy years of age I felt more intensely sexual than I have felt for years and years. I was thoroughly enjoying myself, but before it came to a climax I awoke.

"The sexual feeling in the dream was as strong as it can be, stronger than in my sexual relationship with my wife."

This dream, or rather the main interpretation of it, explains why a man can be married and yet on account of a mother-fixation still suffer from a lot of undischarged tension. The psychopathology of this man's condition, and of anxiety states due to mother-fixation, is revealed by this dream. It is as follows.

The infant's developing libido or emotional energy naturally attaches itself to its mother, and if this development, having reached a sexual level, fails to become attached to another woman, its first and most virile fruits are, as it were, locked up in mother's storehouse. With the subsequent rejection of mother as his sexual object this early sexual energy suffers repression, together with the repression from consciousness of mother as the love-object.

Hence this great storehouse of energy fails to be transferred to the new woman, the wife, and remains for ever as it were locked up, with its tensions unable to find relief. It is the energy of this repression which contributes to the symptom of anxiety states and hysteria.

In the dream this patient was, through the equivalent of a masturbatory act (massaging the head), tapping this source of sexual energy and he found it more abundant than that available for his wife. This was possible only because he was asleep, but even then the censor was sufficiently alert to prevent the final relief of tension, and to awaken him before this could occur. Compare his adolescent habit of inhibiting the orgasm when masturbating.

That is why he felt during the following day a certain amount of nervous tension. It had been mobilised and promised relief, *but as in his other sexual experiences both of adolescence and of maturity this final relief had been interrupted by the vigilance of the unconscious censorship.*

As a result the only outlet it could find was in the process of symptom-formation.

An instance of the liberating effect of free association of thought under analytical conditions is shown in the fact that this patient declares that he has had more dreams in the fourteen days of his treatment than he has had in the previous fourteen years of his life.

From this brief sample of analytical material we may see that there are various factors at different emotional levels which contribute to the psychopathology of an anxiety state. The two principal levels are: the physical, which was brought out exceptionally early in treatment, and the emotional relationship to other persons past and present which contributes to the psychological or hysterical element in the anxiety state.

This relationship though consciously only one of ordinary filial attachment to parents, and affectionate or other mental attachments to various persons, has, as his dream may show us, repercussions upon the unconscious phantasies which are the psychical essence of the sexual life.

It is failure to make satisfactory adjustments at this unconscious level, with its consequent inhibition of natural psychosexual freedom, which results in the damming-up of tensions. The patient becomes conscious of these tensions often only as a feeling of strain or irritability. If their pressure is unduly great they find alternative outlets independent of the ego, and show their opposition to it, in the form of manifold symptoms such as those of which this patient complained.

The ego finds its control undermined by these unwelcome

with the retort, "It is about time *you* gave *me* satisfaction."

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intruders and naturally loses confidence and may become absolutely terrified of what is going to happen next. As there are no bogies outside, and those within are unconscious or invisible to the patient, the result is his complete mystification.

This man's initial improvement was due in part to the uncovering of his mystery, and in part to his illusion that having now discovered his enemy he would have little or no trouble in completely mastering him. He was partly right and partly wrong.

Symptoms are only possible when the conflicts responsible for them are unseen and unknown. On the other hand, when our enemy is detected the fight is not over, perhaps it is only about to commence on an open or conscious plane.

In practice it may be discovered that this "enemy" is really no enemy at all but only our very selves, our deeper selves whom we had previously refused to recognise.

SECTION IV

SOME MORE
SEVERE ILLNESSES

CHAPTER XVI

EPILEPSY AND HYSTERO-EPILEPSY

No claim is made that the typical case of idiopathic epilepsy is subject to psychological cure, though each case which I have personally investigated has shown a variable degree of psychogenic factors in the production of fits. A matter which I think is commonly missed or ignored by neurologists is the fact that even the typical epileptic can be, and often is, subject to psychological tensions which, if not directly responsible for the origin and continuation of his fits, invariably have some influence upon their frequency and severity. But apart altogether from the symptoms of epilepsy itself, such patients are often suffering from a concurrent psychoneurosis more apt to be ignored by doctor and neurologist alike on account of the fact that they have the major epileptic symptom.

A case that came to my notice the other day was that of a man of forty-one who had suffered from both major and minor epilepsy for eighteen years, since he was twenty-three. The point of interest was that his attacks had become very much worse during the past three years, and what is more, it was only during this latter period that he had taken to worrying in almost an obsessional manner about them. Of course, he explained the worry on the grounds that they were now so very much more frequent, the major attacks being as often as once a month and the *petit mal* as frequent as half a dozen times a day, despite every effort on the part of the neurologist treating him to control them by an increase in his regular barbiturate dosage.

The history of this alarming exacerbation in his symptoms was of particular interest. It occurred in the early years of the war when the drug which he was habitually taking (prominal grains 3 t.d.s.) became un procurable. He was already frightened when they put him on an equivalent dosage of epanutin. Sure enough, within a week he had an attack of *grand mal* and immediately his worst fears were confirmed. From that moment the attacks of *petit mal* became a daily instead of a weekly

occurrence, and instead of as previously almost ignoring his affliction, he became obsessed with worry about it. The history of his past three years has been one of continued obsessional worry, insomnia and epilepsy, with sometimes as many as six attacks of *petit mal* per day. No amount of medication has been able to arrest his grave condition.

On investigating his current sex life, a step usually ignored by the neurologist with his attention focused exclusively upon the epileptic symptoms and their medication, it transpires that from the moment of "the incident" of the unobtainability of prominal and the substitution of epanutin with this tragic sequel, he has practically lost all sexual inclination, having had sexual relations with his wife only once or twice in the course of the last three years and not at all for the last two. These recent symptoms—anxiety, worry, insomnia and asexuality—taken together leave no doubt in the mind of the psychologist that this patient is suffering not only from idiopathic epilepsy, as he has been from the age of twenty-three, but also from a *superimposed acute anxiety state*. The psychopathology of his condition is therefore briefly as follows.

When, three years ago, he found he would not be able to obtain his accustomed prominal, he was afraid. This fear was confirmed and underlined by an attack of *grand mal*. The resulting fright put a stop to his natural sexual rhythm, for though epileptics are known to be sexually sub-normal—an observation which I think has not claimed the attention from neurologists which it merits—this patient had been in the habit of regular sexual relationship at least once or twice a month. His fright effectively stopped his libido from pursuing its natural pleasure-giving and tension-reducing course through sexuality and orgasm. The resulting tension being denied its outlet resulted in a production of anxiety symptoms including obsessional worry and some insomnia.

But the point of special interest for the psychologist is that the exacerbation of his attacks of epilepsy, particularly those of *petit mal*, now often as frequent as six times a day, was coincident in time with this fright, stopping of sexuality and resulting damming-up of libidinal tension. *Does it not appear that this libidinal tension, unable through anxiety to obtain an outlet in sexuality, is responsible at least, not only for his crop of anxiety symptoms, but also for the augmentation of his epilepsy*, even if the same process is not

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actually responsible for the existence of all the phenomena of idiopathic epilepsy?

In my opinion, the appropriate treatment in this case, in addition to the regular administration of drugs for epilepsy, would be psychotherapy for his recently acquired anxiety state. I have not yet had the opportunity of treating this patient, but one would expect that if his anxiety state was successfully treated two results would ensue: one, a return of his sexual life at least to the degree previously experienced before his shock; and two, a reduction of the incidence of his *grand* and *petit mal* attacks, at least to the minor degree which was habitual to him before the occurrence of his fright. Even if such hopes are extravagant, a matter which should not elude the neurologists is the fact that this man is chiefly plagued by an obsessional worry, together with many other minor symptoms of anxiety, and the psychotherapeutic treatment of these would certainly make his life far more tolerable.

The following is the record of a case, diagnosed as epilepsy, which I had the opportunity of analysing to a stage when the major attacks disappeared in favour of hysterical symptoms.

Hystero-Epilepsy: A man of forty-five complains that for the past eight years he has suffered from occasional fits, which come without the slightest warning, include total unconsciousness, and are followed by a dazed condition with defective memory. The diagnosis formed had been that of epilepsy, either idiopathic or psychogenic. He exhibits other symptoms which include: unreasonable aggressiveness, nail-biting, constipation, restless nights, headaches, mental confusion and occasional tremblings. His character also deserves to be classed as a symptom: he is a terrific fighter. He wants to conquer his illness by sheer determination and will-power. He is always under considerable tension and unable to relax. If he rides in a bus or tram, he is mentally pushing it along faster all the time. During treatment at the clinic, when told the number of the particular consulting-room allotted for the interview, he always rushes past it at great speed.

Family History: His mother had eight successive still-births. The patient is the fourth living child. His father was a drunkard. The patient's earliest memories are those of his father returning home drunk in the early hours and beating his mother, while the patient peered at the scene in terror. Throughout infancy

he experienced extreme poverty and insecurity. In adolescence (seventeen or so) he fought his father, whom he had always hated, knocked him unconscious and left the house.

The patient has been married for about fourteen years and has one child, a daughter, aged thirteen. His sexual life, since the birth of his daughter, has been *coitus interruptus*. The frequency of intercourse gradually diminished and it seemed that an increasing irritability, particularly towards his wife, took its place. When his attention was drawn to this, he made strenuous efforts to suppress it. He succeeded, and soon after he had his first nocturnal attack or epileptic fit.

Physical examination has revealed no signs of organic disease. Wassermann and Kahn blood tests proved negative.

Outline of Clinical Notes: The great mass of material produced by this patient during a long analysis had to be sifted and classified for the purpose of clear presentation. All the material is relevant to the psychopathology of his fits, but it may be enough for present purposes to give brief representative extracts under the following headings: Childhood Traumata, Sexual Elements, Aggressive Elements and Self-mutilation Elements. All are interrelated, though the aggressive elements appear to be the most abundant.

Before analysis, every fit had been totally unconscious and unremembered. Description by his wife showed them to be typically epileptic or epileptiform. They occurred regularly, during sleep, between 3 and 4 A.M. Before analysis the patient denied aura; on the other hand, his wife said his face would blanch momentarily before he collapsed. There was a single cry or sound, total unconsciousness, a momentary spasm or stiffness followed by clonic movements. The tongue was frequently bitten, bed-wetting had occurred, serious injuries—including a comminuted fracture of the arm—had been sustained, and after the fit the patient was in a post-epileptic amnesia for several hours. Usually he had to go to bed, or remain in bed, for the rest of the day.

ment be produced on the analytic settee merely by reference to the emotionally charged material. It seems that from having the characteristics of epilepsy, the fits became those of hystero-epilepsy, and finally those of hysteria.

Clinically, everything leads back to the infant-parent emotional relationship, and, therefore, it is particularly relevant to begin with a reference to this.

CHILDHOOD TRAUMATA

Here is a verbatim extract from one of his sessions:

"I was a little boy. We lived in a tenement—two rooms. Night after night, peering through the crack of the door between the bedroom and the living-room, I saw father struggling with mother. Father shrieking and running round the room after my mother. Mother shrieking too and running away. He would catch her and swing her by the hair. Something terrible was happening to my mother! . . . Or perhaps it happened to me. . . . I felt it was happening to me. I was in terror."

(For a moment he chokes and cannot speak.)

". . . Perhaps it was a plant-pot went through the window.

"I have got a job to speak sometimes. I feel the cause of the trouble is not far off. Perhaps it was on one of those occasions that something happened, or perhaps it was the life I led day after day—the continuous scratchings on the memory of all that sort of thing. It made a deep wound in my memory. Damnable rows, shoutings, ravings and screamings! My poor mother!

"That Christmas! No food in the place, rags and starvation and one orange in each of our stockings. My mother was starving, but somehow she managed to get three oranges. That she, a good mother, should be treated like this! Should suffer! It's agony! Crucifixion! . . . Like Christ on the Cross. He gave up the ghost. It is like my dream—I feel curling up like a worm that has been cut in half. It is more than being hurt—it's agony—it's like the fit."

The patient writhes on the settee while he remembers these acute emotions of his childhood. His action is a mild reproduction of movements that take place in or after his fits. The fists are clenched and he appears to be wrestling with himself with slow, tense movements of the arms, at the same time emitting guttural sounds.

SEXUAL ELEMENTS

Let us pass on to an example of his remarks on the sexual elements which contribute to his emotional tension and to the tendency to its discharge in fits. This material is not nearly so abundant as the aggressive elements to be described in the next section, but all are closely related.

He dreams of sexual approaches to a "most lovely woman. She was pure like the Madonna. She was all for me."

"There is a terrible thought I had as a boy. I have always been trying to forget it. It was when my mother was dead." He relates how he was deeply upset by sensual thoughts of touching his mother.

"I believe I only dared to think this after she had been buried when it would have been no longer possible to do it in reality. It was a most exciting though a terrible thing to think. It gives me a sort of agony. I wish I had never thought of such a thing."

He complains that the dream should have culminated in a nocturnal emission. "I never have that. As a result I feel the tension is still there. In the dream I felt I must have sexual intercourse with her. It would be terrific. It would pull my guts out with its terrific intensity. And that is like a fit only there is a terrific frustration. I can't touch her. If I don't I shall kill her instead. It will be like murder. I can't. It's like being on the Cross. Yes, it is."

He starts having a fit on the settee. He screws up his hands and arms, writhes and struggles with himself and goes livid, ejaculating groans between his clenched teeth. Presently he continues:

"That is like the Cross—terrific . . . to get an erection like that turns your inside out. You can't do it. Like murder! Like the Cross!"

To keep him talking, I ask:

"Who is being murdered on the Cross?"

"I am. The mother on the Cross. The girl! It's the agony of being raped."

and a psychological mutilation (or "rape") of himself. The fit is the dramatisation or pantomime of these happenings.

In the following section, under the heading of Aggressive Elements, we shall see that the corollary of the above is also true, namely, that if he achieves sexual relief, the aggressive urges may be robbed of their power or intensity.

AGGRESSIVE ELEMENTS

The patient learns that he is not going to get the promotion for which he has worked for years. That night he dreams.

"I was standing up when a baby bit my hand. I looked at it and saw scratches on my fingers. I then bit the baby in the face. The baby's eye came in the way and I was afraid of bursting its eyeball. I couldn't do it. It was too terrific."

In free association he says:

"The dream is something like a fit. I bit the baby. I'd like to bite off the manager's ear." (He blames the manager for his failure to get promotion.) "The bursting of the eyeballs would be a terrific fit." Later he compares this to an orgasm.

He then tells me that a day later he deliberately had a conscious fit in church during the Sunday service.

"I had been thinking about the office manager, working up a phantasy of revenge on him. I deliberately went to the back of the church, where nobody would notice me, and I let the feelings of killing him get the better of me. I let it happen and I laid myself out in a fit.

"The phantasies were something like this. I would go to the office while the manager was alone. I'd hit him on the head—I'd take four rusty nails and nail him to the floor, that is, crucify him to the floor. I'd bite off his ears. Then I'd take the office thing for making holes in paper and make holes all over his back so that when he was in hospital he couldn't lie on his back. He doesn't believe in psychology, so I would leave a note with him to tell him while in hospital that here he had a practical demonstration of psychology.

"Then I went on to a phantasy where I'd tear him to pieces. I would cut his arms off. Stab him. Torture him. Cut his genitals off and stuff them in his mouth. I thought of taking out his eyes, but I couldn't do that. That was too terrific. If they took out my eyes it would be terrific. I couldn't bear that."

He squirms on the settee for a few moments. It appears that

castration feelings are more realistic when the eyes are used as conscious symbols (cf. Oedipus).¹

He then continues:

"I know it is abnormal. I know it's murdering the father" (cf. childhood traumatic memory of his father). "But I don't want to act a play. I want to *do* it. I don't want to be a Hamlet; I really want to murder him" (the office manager). "Murder has got to be done. Then I could have my revenge *and get well*. It is only by revenge one can get well, otherwise it is bottled up and causes a fit. I thought all this in church and then I thought, 'What am I to do? I'm in a helpless position like I was as a boy watching that swine murdering my mother.' Because I was helpless I had to stick to my crucifixion. I thought of those eyes coming out or bursting, and then I flopped out and started having my fit. I murdered myself instead.

"It did relieve me a bit, though it could not have been a very bad fit; and, strangely enough, that night I felt sexual and had an unusually satisfactory intercourse.

"And this was the curious thing. On Monday morning I wanted to go on with the revenge phantasy against the office manager but it wouldn't come. It had lost its spunk. It seems I'd got rid of the poison by having had the sexual relief."

Is this evidence of a relationship, at least in source of energy, between sexual tension and the tension which produces the fit? If it appears that sexual relief robs the fit material of its energy (rather than weakening the power of controlling fits), the corollary would be that inhibition of sexual satisfaction at least contributes to the energy of fit production.

patient, under free association, produces thoughts that bear on every aspect of the subject. At one of his sessions he related the following dream:

"Flames were coming out of a cracked gas-pipe in my kitchen. I thought the whole place would blow up any moment. I shouted to the office manager, 'My God! Find the gas main and turn it off!' I thought he would know where the gas main was. It was not found but no explosion occurred."

His free associations are as follows:

"Thinking of a terrible explosion is enough to make you tense—enough to make you have a fit. In this dream the office manager is you" (the doctor) "and I wanted you to turn off the source of the epilepsy. If I had intercourse it would be like letting out the gas in flames, and if it got to the main reservoir there would be such a lot of gas under tension that there would be a terrific explosion. That would be the fit. If I had not had the sexual intercourse last Easter, the fits I had then would not have occurred or would not have occurred at that time."

He remembers how, on the occasion of his first and only post-pubertal masturbation, he was terrified at the sensation of orgasm.

"I couldn't stop the feeling. I got a terrible fright, like in the dream. But I did turn *that* off at the main. I never masturbated again in my life. And now these damned fits have broken out. Is it through turning off the masturbation, the sex relief, or is it through letting it out as I had done just before I got those fits at Easter?"

"What am I to do? Talking does not give enough outlet or relief. Talking is an inhibited way of discharging energy. Sexual intercourse is often not free enough. The fit is a better way—I was going to say a 'more natural' way—of discharging the energy. The epileptic fit especially is wholly without any inhibition!"

"What am I to do? If I dam up all my feelings, I burst. If I have sexual intercourse, it seems I am just making a hole in

¹ This is a clinical confirmation of a general statement made in biological terms by Sherrington. "Speech, since it provides some degree of externalisation of energy, may be regarded as standing between musculo-skeletal behaviour (*i.e.* action) and thought, and is also a manifestation of partial motor inhibition . . . the degree of relief of instinctual tension depends on the degree of sheer motor component in the expression. Thus action gives the greatest relief, thought or phantasy the least" (Sir Charles Sherrington, Rede Lecture on "The Brain and its Mechanism", delivered in Cambridge, December 1933).

the dam and precipitating the burst—or, as in the case last Easter, a series of bursts.

"Can't you turn the thing off at the main—cut off my penis—castrate me? That's the cure!"

Is it possible that the fright he got at his first, and only, post-pubescent masturbation caused him so to dam up his libidinal energy that its only outlet became the bursting of the dam in the form of a fit, and that the condition he has produced is still one of such tension that sexual outlet may sometimes be inadequate to relieve it—a weakening of the resistance rather than an adequate discharge of the tension? Is he still so frightened of adequate sexual outlet that he mostly holds it in until its only outlet is the fit (which he has since similarly feared)?

There is much evidence that the patient's strong aggressive tendencies towards those in authority over him (father-figures) are a direct re-living of the frustrated hatred he felt towards his real father when, as a child, he watched him ill-treating his mother. His hate, including the violent phantasies of revenge, is not confined to his present superior, the office manager, but applies to almost every one of the several managers and similar figures that he has had over him throughout his life. The identity of the aggressive tendencies and phantasies with those of his childhood is perhaps revealed more clearly when he comes to experience them toward his analyst during treatment.

The analyst, after being violently attacked in his rôle of father, thereupon immediately becomes a mother figure, and the most real emotion the patient experienced during his sessions was the agony of remorse (self-reproach, self-punishment, self-mutilation) following some such attack, when he discovered that in his own mind it was a mother-figure which he had attacked. A process similar to this in infancy led, in his later life, to his fear of, and renunciation of sexuality as well as aggression. More than anything else it was his reaction to such a situation as the above which produced the conscious fits during the sessions.

AGGRESSIVE AND CASTRATION ELEMENTS WITHIN THE TRANSFERENCE

For instance, he began a session with a few minutes' silence, followed suddenly by a violent, conscious fit. On recovery he said:

"When you said you could give me only half an hour I had

to tell you about your bloody Harley Street snobbery. I felt a great feeling of rage against you. While I was lying on the settee in silence, I murdered you—as I have done the manager and as I have wanted to murder my father.

"Then, I thought of all the hours you have spent with me in order that I shall get better. I thought, 'Could ye not watch with Me one hour?' You have watched with me; you have been kind to me to make me better. It was an awful smack in the eye for me. I had murdered you because you had got on your hind legs, and you were the good one after all. I had murdered the good one, the innocent one (mother). I should have murdered myself. It's one long terror. Then the fit arose at that point. It's like hot meeting cold. Something very hot meets something very cold, black meets white, and the fit results. (Hate meets love) I rush all hot to murder my father, and then I find it is an innocent person (mother) whom I am murdering, and the murder feeling turns inwards. I murder myself. I suffer agonies I beat myself, clench my hands and fight myself. I twist and wriggle in agony, kick myself, break my arm. It's an agony—that's what the fit is."

Discussion and Psychopathology: At the outset it should be admitted that although several beneficial changes have occurred as a result of psychotherapy, including the disappearance of the epileptic (unconscious) fits, and the progressive diminution both in frequency and intensity of the hysterical (conscious) fits, and also marked character changes, including a disappearance of his aggressive nature,¹ nevertheless it has been considered advisable to continue his luminal (gr. i, o n.), as he still occasionally complains of feelings of tension and of the breaking through of irrelevant words and thoughts accompanied by strange feelings. These are suggestive of *petit mal*, and it has hitherto been found impossible to resolve this element in his illness as there appears to be in it no material accessible to analysis, although occasionally a word or two can be captured. These words seem as irrelevant to psychic structure as the involuntary muscular movements of the fit. In spite of these unfavourable considerations, perhaps enough clinical material has been given to justify discussion of the possible psychopathology.

¹ He is no longer the aggressive, quarrelsome person he used to be, and his wife reports their domestic and sexual life is much happier.

In considering inherited characteristics, may we suggest a comparison between the violence displayed by his father outwardly and the violence displayed by the patient inwardly in the form of a fit? His father broke everything and everyone in his environment; the patient broke his own arm. The successive repressions, first of sexuality and then of aggression, observed in his personal history, immediately prior to the outbreak of the fits, are revealed by analysis to have had their equivalent in his infancy and early childhood. There is evidence that his first emotional difficulties arose when he found his sexual impulses, still incompletely differentiated from aggression, tending to direct themselves towards his mother.

He was too small to attack his real father, but this "devil-father" within himself he could and did attack, on behalf of his beloved mother. It was thus that he came to suppress his sexuality, which process is later revealed as an inhibition of adequate sexual indulgence. Subsequently, he had perforce to suppress also the aggressive tendencies which were apparently reinforced in consequence of the sexual repression.

As a child he witnessed his father's behaviour, took sides with his mother, and directed his violence against violence. It was this violent suppression of his tendency to violence which occasioned the outbreak of the fits. In technical language we would say that the instinctual aggression within him was handed over to his super-ego (conscience) and directed against any aggression or sexuality still tending to be discharged by his instincts. The process is called anti-cathexis. Aggression had now become a super-ego force directed against the original instincts of aggression and sexuality. So the battleground which his father pitched in the domestic parlour was all, as it were, within the person of this patient.

"father". Immediately his aggressive urge, already in violent motion, is arrested and turned back upon himself, and he suffers the agony of its violence. He wrestles with himself in a fit.

Though he rushes at everything like a bull at a gate (and probably for the same reason as a bull charges a gate, namely, inadequate sexual relief), he nevertheless keeps pleading for hypnotism or castration as the only cure. He wants to solve his problem in the usual inverted *Oedipus* fashion, namely by submitting to a good father image, having his aggression and sexuality removed (castration) and becoming a "good" and "innocent" person like the mother. Perhaps the fits were a form of self-castration, an unconscious or automatic way of putting his "cure" into operation. They certainly left him distressed and ill with the psychology of a "damaged" person.

If his psychic energy has been inhibited from developing along the two great primitive paths of discharge, that is, through the aggressive instincts and the sexual, and if in consequence the tension becomes too great to hold, there remains at least one still more primitive path open to it, namely, the path of the undeveloped and unorganised motor innervation which existed from birth. It was along this path that the surplus of his emotional tension found its outlet in the form of a fit.

That the process of fit-production has something in common with such major hysterical phenomena as somatic conversion and convulsions is made evident by the actual transition during treatment to manifest hysterical fits. Tensions which formerly were apparently meaningless and devoid of psychic content and which produced unconscious (epileptic) fits have, as a result of treatment, become linked with their original and appropriate memories and ideas. In consequence, the tension or affects have been invested with psychic content, and their discharge has become conscious and relatively under the control of the ego.

The corollary to this clinical manifestation is obviously that the reverse process was responsible for the former epileptic nature of the fits, namely, that a successful repression from consciousness of highly charged memories and thoughts left their charge, their tension, or affect, no alternative but to discharge itself automatically through the musculature (as though it were a force independent of the psyche), in opposition to the ego, and, therefore, at the expense of consciousness. This is what took place in the epileptic fit.

The reduction, almost to vanishing point, of the epileptic fits (he has had only one in the past two years), and the advent of conscious hysterical attacks as a substitute, would indicate that, in this case at least, there is a relationship between the sources and mechanism of epilepsy and those of hysteria. The question arises: How many cases of so-called idiopathic epilepsy have a similar psychopathology, and are therefore similarly subject to amelioration by psychotherapy?

CHAPTER XVII

OBSSESSIONAL NEUROSES

IT may appear contrary to orthodox usage, to place Obsessional Neurosis under the heading of "More Severe Illnesses" and separated from the other favourite psychoneuroses, *Hysteria*, by so strange an intruder as *Epilepsy*. After placing Hypochondria, a symptom-complex most constant in Involutional Melancholia, and Drug Addiction in the group of the *Hysterias*, it may seem that I am again flouting the usual textbook order by this further example of arbitrariness.

In extenuation I would point out that this unorthodoxy is more apparent than real. This case of obsessional neurosis really follows on the cases of hysteria. The descriptions of "The Epilepsies" here given are really descriptions in the first instance of an anxiety state in an epileptic and in the second of epileptiform symptoms in an hysterical. And might not the "blackouts" in the first two cases of hysteria there given, if they were recurrent, be regarded as epileptiform? The object has been to show that there is not necessarily any sharp line of demarcation between psychogenic illnesses—not even if some of them are labelled epilepsy.

All that has been done in our hitherto general arrangement of progressing from simpler to more complex or from minor to more severe psychogenic illness is that we have drawn a line part way through the *Hysterias*, labelling the illnesses below the line "*More Severe*"—as indeed they are—and beginning with a consideration of hysterical mechanisms in epilepsy and an epileptiform expression of hysteria.

In proceeding to a case of obsessional neurosis I am still following the general principle of progress to more severe illnesses. For though minor forms of obsession are as common as or commoner than minor hysterias, and are indeed an ingredient of so-called normality, severe forms such as that here described are graver than hysteria. Their nuclear root lies in an earlier fixation of the libido. Whereas the nuclear root of hysteria is the Oedipus complex or the genital level of libidinal organisation,

that of obsessional neurosis is pre-Oedipus, namely the anal level, and very severe cases may be regarded as intermediary between psychoneuroses such as hysteria on the one hand, and psychoses with oral fixation levels such as manic-depressive psychosis and schizophrenia on the other hand. Indeed they have been known to deteriorate from the character of a psycho-neurosis to definite evidence of the last-named psychosis. Thus we see that this case is rightly placed in our order of progress from the less to the more severe psychogenic illnesses.

A Case of Obsessional Neurosis: It is some time now since I was consulted by a bland young man with a strange request. He asked me if I would kindly explain to him exactly how one performed the act of sexual intercourse.

Reflecting that cats and dogs and even the stupidest of animals have little difficulty in performing this act without consulting a medical psychologist, I recognised that this enquiry on the conscious plane showed some deficiency in the unconscious, and I was not disposed to emulate the authors of some of our banned books, nor may I add to emulate those preoccupied with the even more morbid tendency to ban, so instead I asked him to tell me everything which led him to come and make this unusual request.

The story that unfolded itself was that, in spite of affectionate desires towards members of the opposite sex, he had attained the age of twenty-eight with only rare instances of any physical contact, and this only of an affectionate nature. He had never fallen in love, nor had he ever attempted any sexual approach.

Now, suddenly, this had been thrust upon him. An older woman of his acquaintance was endeavouring, with his conscious acquiescence, to accomplish his seduction with a view to securing him as a husband. He had tried his best to play his allotted part in the situation, but had failed most miserably. Therefore he had come to a doctor for instruction.

In short, this young man was truly and completely impotent. Some degree of impotence in men, like its counterpart, frigidity, in women, is perhaps the commonest manifestation of psychogenic illness. In this case the condition was unusually extreme. Nevertheless I do not wish it to be thought that every case of complete impotence has such a very morbid psychopathology as was discovered in this instance.

I contented myself with indicating to the patient that he was in the hands of forces inaccessible to his conscious control, and that no amount of conscious instruction or knowledge would make one iota of difference to his psychosexual functioning. Therefore he had best resign himself to the facts of his nature, and cease to torment himself by fruitlessly trying to coerce his nature into behaviour of his conscious choosing. The latter is superficial, the former deep-seated.

He left me obviously dissatisfied and determined to persevere.

Six months later he consulted me again. The most extraordinary things had happened. Far from accomplishing his aim, he had on the contrary found it increasingly difficult even to attempt a physical relationship with a woman. Instead, he was finding himself more and more preoccupied, not with sexual worries, but with compulsions, obsessions and phobias which were threatening to make his whole life a perpetual misery.

The central point of these preoccupations was the idea that he was contaminating everything and everybody with which and with whom he came into the slightest physical contact.

The transition from his original difficulty to his more distressing present difficulties had come about somewhat as follows. In anticipating physical contact with his friend he had first to make sure that he had carefully performed his toilet, that his hands were scrupulously clean.

Subsequently, this was not enough. He had to take the precaution of a bath. The precautionary need increased and he had to indulge in two or three hand-washings and even in a succession of two baths.

Finally, in spite of all this over-cleanliness, he did not feel clean enough to approach her at all. So that ended that situation!

His next compulsion was to get away from the hotel in which he lived, or to induce her to remove. But even when this further operation had been accomplished he found himself in no better position, for the precautionary cleansing of himself continued and increased.

His aim was to ensure that he would on no account spread or disseminate his bodily matter on to any persons or things in his vicinity. The hands, being the chief organ for this dissemination, came in for the familiar ritual hand-washing ceremony. He would wash his hands three times in three separate changes of water, and if he could not use a clean towel for each drying he

would make sure that it was a different part of the same clean towel that was used.

Further, his face towel had to be folded with what he called the clean side inwards and it must be protected from any contact with his bath towel, which latter he felt was more heavily "contaminated". It was a constant worry to him that the maid did not carry out this precaution.

In addition, he himself was constantly having minor "accidents" whereby clean, or uncontaminated, things would come in contact with the contaminated ones and the whole process of de-contaminating would have to begin afresh.

The absorption of time was considerable, so that he tended to become increasingly late for his duties and appointments.

Accidental contaminations accumulated, and resulted in his feeling uncomfortable throughout the day. For instance, when doing up his trouser button and before he had had time to wash his hands his coat sleeve would brush against this button and thereby he felt become contaminated. Subsequently contact between this sleeve and his coat would spread the trouble, and, in spite of his having washed his hands, contact of coat sleeve and outer part of his pocket would lead to a re-infection of his hand and the contamination of the entire contents of his pocket.

Thus he constantly felt himself to be going about one mass of contamination. The mental discomfort which obsessed him throughout the day is indescribable. Further, he presently found that it was almost impossible to take a bath, for, far from this seeming to be the cleansing process which most people enjoy, to him it seemed that it spread contamination from the more contaminated parts of his body to every portion of its surface.

His condition after a bath would be even worse than that before it, and the clean clothes which he would put on would immediately become contaminated from the surface of his newly bathed skin.

The strange fact now emerged that, with all this super-cleanliness, he nevertheless did actually tend to soil his underwear, though to a very slight but to him terrible degree. It would seem at first sight that his sphincters (bowel control muscles) were not under a perfect or normal degree of control, but to this we must add the discovery that they were usually over-controlled in that he habitually suffered from severe constipation.

In the course of analysis it appeared that this "constipation" extended to all ordinary activities in life and even to his thoughts and mental processes.

Thus we see that this patient, who first presented himself with a very evident conflict on the sexual plane, a conflict strong enough to cause complete impotence, had now regressed to a similarly all-absorbing conflict on what in psycho-analysis would be called the anal level of libidinal development.

This conflict was expressed physically by his sphincter in an alternating excess and deficiency of control, and mentally in his "contaminating" accidents and in his cleansing rituals.

His interest in the opposite sex, and indeed in all sexual matters, had practically disappeared. Instead, we find almost his whole life preoccupied in dealing with these auto-erotic excretory activities.

This is a very severe neurotic illness the structure and mechanisms of which are not very far removed from those of that perhaps most distressing of all mental illnesses, namely, melancholia, or 'more probably, a depressed phase of schizophrenia. Before we ask ourselves the question as to what hope there is of alleviating this miserable state of affairs we must ask what light analytical investigation can throw upon its psychopathology.

Psychopathology: Early in treatment he brings me the following dream: "My mother was lying in bed. She seemed to be terribly ill. She had had some operation and I thought she was dying. Somehow I felt it was all due to something that I had done. I felt awfully miserable and wished that it had not happened. I felt that I would do anything and everything in my power if I might have prevented this or if I could undo it."

His association to "lying in bed" is his woman friend lying in bed. With reference to "operation" he says "childbirth", and in reference to something he had done to her he suggests first "sexual intercourse" and subsequently "contamination". In association to "prevention" he says "preventing the contaminating no matter how much trouble I take", and the undoing is similarly "eradicating or cleaning up even the slightest contamination".

With regard to "terribly ill" he makes the further illuminating remark: "I am terribly ill." In this we see an element of identification with his mother. This is further brought out in

the latter part of the next dream, though at the beginning of this dream he shows a tendency to identify himself with his father.

"My father and I were playing golf together. We were in the club-house. He asked me to have a glass of beer. I refused. He kept pressing me. He got annoyed. We moved into another part of the club and again he asked me and again I refused."

The interpretation brought out by his free association of thought is that he is at first following father's footsteps in ordinary normal heterosexual activities (the game of golf). "In the club-house" is the interior of his mother's body where father and he are together. (This is part of the reason why he is impotent.)

But then the situation changes, and his father begins to press his, father's, attention upon him. This attention takes the form of a glass of beer which father presses him to swallow, that is to take in *orally*. With reference to the glass he says, "It was a tall glass—possibly a phallic symbol."

With reference to the beer he stresses its colour and remarks with disgust, "No wonder I refused it."

He then remarks that his constipation developed when he was living at home and was due to his hearing his father about the house when he, the patient, was in the lavatory. He says, "I felt at any moment that he might try the door and I got a contraction which made it useless for me ever to try to use the lavatory at home. That is how my constipation began. My father is a very pushing man."

After this the patient was silent and was unable to produce any more thoughts during the rest of the session.

Finally, he said he wished I would talk as otherwise he feared I would get annoyed. I then interpreted to him that he was playing out this dream situation here and now within the analytical session.

He responded by remarking that he now had some abdominal disturbance and would like to leave the room. This request was refused, but nevertheless he produced no more analytical material during that session.

I think it may be worth while giving just one more of his but to^s in order to indicate the relationship between bowel over-conrolleur cultural sublimations.

stipation. ed to clear some rubbish away. I thought this is

not the kind of work for me to be doing; I will see the manager and get something more satisfactory to do."

In association of thought he says: "This manager has a flair for psychology." He identifies him with me, the analyst. "Clearing the rubbish away" he connects with his decontamination activities.

But his most interesting association is that of money. He says: "Yesterday evening I thought I would get out my personal accounts for the last two months and summarise them. I have kept a careful record of all the money I have spent with the idea of analysing what I do with my income, so that I could cut out unnecessary expenditure and save more money."

"I recorded every penny I spent in a book, entering it up each evening and making it balance with the money in my pocket. My idea was to make out a summary of the accounts for the two months with expenditure recorded under different headings such as board and lodging, clothes, meals out, fares and entertainments.

"Unfortunately, before I could get started I got an unstable feeling in my abdomen and all my bowel trouble and obsessional phobias started again. I felt very disappointed with myself. I do my best to organise my affairs on a proper systematic basis and then these troubles and the contamination phobia crop up and knock me back to my usual level."

That is to say his attempted sublimation reverts to its primitive origin.

At this infantile level it is full of conflict and has associations to his mother and father. In consequence of the conflict he gets abdominal disturbances instead of healthy evacuation. Moreover, this conflict has its equivalent on the mental plane resulting in his phobias and obsessional activities.

It is impossible to understand a case of this very deep psychopathology without reference to the discoveries and theories with which psycho-analysis provides us and which throw such an illuminating light upon all these matters.

It is an enormous subject. Indeed, it can be identified with psycho-analysis itself. The most we can attempt is to give the briefest possible epitome of the essential elements in the theory. If it serves no other purpose, it may show those who erroneously identify psycho-analysis with its sexual theory that this is a very naïve misrepresentation of the subject.

To begin with psycho-analysis regards sexuality as an end product, or rather adult sexuality with its object-love as the highest organisation on the primitive level of a mass of less organised and more primitive component instincts.

We will here leave out all the cultural displacements or sublimations which comprise our civilised life and occupy the greater part of our conscious thinking and activities. Here we are concerned only with the ordinary animal mechanisms reaching their final organisation in object-love and sexual congress.

As Freud pointed out many years ago, psychological development follows the pattern of physical embryonic development, only it is many years later in its correlated transitions. The embryo develops from the primitive streak and has a blastopore situated at its anterior, or mouth end, and subsequently an anus situated at its posterior end with incidentally an open connection with the neural canal, long before it shows the slightest sign of a urogenital apparatus.

In the light of this observation perhaps we should be less surprised to learn that psycho-analysis finds the life urges, pleasure urges, primarily connected with mouth, or oral activities, and later connected with bowel, or anal activities, long before any genital interests succeed and to some extent replace them.

In short, psycho-analysis and our own clinical observations teach us that developmentally mouth erotism is superseded by anal erotism, and that only subsequently a similar and perhaps reinforced quality of erotism passes over to the genital organs.

Put in another way and somewhat amplified, we may say that the libido, or life urge, with its erotic quality passes through various stages of development before it reaches genital maturity.

These stages are classified as (1) the early oral (mouth) stage, or sucking stage; (2) the later oral or biting stage; (3) the earlier anal or expulsive stage; (4) the later anal or controlling and retentive stage; (5) the earlier genital, phallic or clitoris stage; and (6) the final genital or fully developed adult stage of libidinal organisation.

These stages are important chiefly because they carry with them certain characteristic psychological interests, preoccupations and activities.

For instance, they each characterise a particular relationship of the mind to the world of things and persons around it.

The first three in so far as they are concerned with *objects*

reveal on deep analysis fantasies of an incorporation, a taking-inside, of the objects in which they are interested. It is only in the last stage that true object-love, as distinct from the love of what is called in analysis "part-objects", is fully developed.

It should be explained here that by object-love is meant the love of a person as such, whereas the love of a part-object would include such things as interest in a particular part of the body with relative exclusion of interest in the person. Feelings of ambivalence, or love and hate towards the same object at the same time, are characteristics of most of these early stages.

It is only such a scheme as this, however fantastic it may sound, that will enable us to comprehend the equally fantastic symptoms and preoccupations of such a case as that with which we have here been dealing—and this, of course, is not an isolated example of a symptom-picture which seems strange to those unacquainted with the deeper levels of the unconscious mind.

Indeed, such a phenomenon as the hand-washing ritual is almost a byword, and it, together with all compulsions, phobias and obsessions, may commonly have a psychopathology almost identical with that of this patient. Furthermore, there is the large field of perversions, sexual and otherwise, not to mention the complementary and more common horror of them, which can be explained and systematically classified only on the basis of this scheme of libidinal development with its successive erotogenic zones.

Psycho-analysis goes further than this and holds that all our cultural interests and attainments are sublimations by displacement of libidinal energy originating in such humble roots. An indication of this was given in the patient's preoccupation with money and accounts.

One may add that one would expect him to be particularly scrupulous in indexing and filing. This actually turns out to be the case. Nothing delights him more than to be given the task of clearing up a mess or muddle at some office where the books and files have been neglected.

Unfortunately his regression to the primitive source of these sublimations interferes with his office efficiency, as it results in the phobia that while he is tidying up the figures he is unable to avoid contaminating the paper and files.

We saw at this patient's first interview a tendency to full libidinal development, at least to stage (5) if not (6). Neverthe-

less this attempt on the part of his psyche was too anxiety-ridden to succeed. He remained impotent.

Anxiety increased and then came this tragic regression, or going back to the fixation point of his libido to the later, and to a less extent to the earlier, anal stage. His dreams indicate that a similar process had been experienced during his infancy.

With the progress of libidinal development to the earlier genital stage he had become alarmed by his ambivalent and destructive phantasies directed towards his mother. He had feared that he was injuring, or destroying her.

At the instigation of anxiety his libido had regressed to the level of anal phantasy, but there too this conflict was not resolved, nor probably was it resolvable, for at this stage the phantasies are markedly ambivalent. That is to say, while the infant expresses love by an excretory activity, he may at the same time phantasy that, *like his behaviour towards his bowel content*, he is controlling, mastering or even destroying the object of his pleasure and love. In consequence, while he indulges in this pleasure as a love act, he may at the same time try to curtail or eradicate it as a sadistic, or destructive, act levelled against the person, people or things which he loves.

Of course, however repressed or unconscious these phantasies remain, they are still potent to disturb not only the bowel function but also the thoughts and conduct and, indeed, the entire mind, as was so evident in the case of this unfortunate sufferer.

Our only hope is that with the revelation of the fantastic nature of this illness and a remembering of the infantile fantasies which originally laid down its structure, anxiety may be sufficiently allayed to permit of a more successful libidinal development to a genital stage and its absorption in object-love.

But to attain such an end the libido will have long and tortuous paths to follow, indeed the paths of the earliest years of infantile development. Some part of it must have travelled them before or the present position would be quite hopeless. Indeed even so analysis of such cases, though not exceptionally difficult, is amongst the longest of all analyses, not excluding those of normal persons, characterological cases and psychotics.

CHAPTER XVIII

DEPRESSION

THE case of obsessional neurosis just reviewed shows us how extraordinarily deep within the psyche the psychological causes of an illness may reside. It shows us also that in spite of this depth these causes may yet be analytically discoverable.

We are now approaching illnesses of such increasing severity that their causation often appears to be deeper than any depths which we can plumb even by analytical investigation—although admittedly their manifestation is principally psychological. This may introduce us to the concept of undiscoverable depths within the psyche. Investigation of the manic-depressive and schizophrenic psychoses often suggests that their aetiology lies deeper than any mental level—lies in fact in endogenous processes, physical rather than mental, endocrinological, metabolic and biogenic processes. If this is so, we as psychologists are investigating only *manifestations* of a disorder whose causes lie outside our province. The impression may often be that this is the truth.

Nevertheless, if we hold the theory that mind-possessing organisms are subject *primarily* to psychogenic alterations with only secondary somatic effects, we must assume that some mental change, however biologically intangible, is primarily responsible for the endogenous “causes” of subsequent mental phenomena. We all know for instance that misfortune, frustration of libido, may change our mood and readily cause at least a temporary depression. Therefore it may be worth examining some of the very minor types of psychotic disorder, however apparently endogenous, such as those of mild depression, from a psychological point of view to see if there can be any psychogenic aetiology in these cases of more severe mental illnesses.

Depression is a condition of mind so prevalent in this modern world of ours that its ultimate causation, whether in the realm of mind or body, certainly deserves every investigation which we can bring to bear upon it.

In studying some case material, the idea may be borne home

to us that depression has been produced by over-civilisation. It is as though in our efforts to adapt our primary urges to artificial conditions we frequently repress, crush or smother those urges instead of achieving their gratification, albeit displaced, through the symbols or toys of culture. Thus the id is smothered or made miserable through its repression, but more obvious than this is the phenomenon of an outraged and vindictive super-ego (*vide* page 223), still active *in spite of the repression*.

The following case may show us some of the morbid processes by which this undesirable result is brought about.

A young man comes to me in a state of acute depression. He can find no cause or reason for this. He has recently married and, in accordance with the wishes of himself and his wife, she is now in the early stage of her first pregnancy.

Psychologically and biologically nothing could be better. Also, he says that for several months previous to this attack of acute depression he had had the happiest time of his life.

"Why is it that this black cloud descended upon me? I was away in the Midlands on war work and was terribly keen to get back to my wife. At last the opportunity came. I enjoyed the first week. Then I felt this trouble coming on. I cannot understand it at all. Am I going mad, doctor? I get nervous about it. When one of these fits comes on I find it impossible to realise that I ever enjoyed anything, and yet I know that I did."

ANALYST: "When one of these fits comes on. Do you mean you have had these attacks before?"

"Yes. I have had them periodically, at intervals of some years, ever since I was fifteen. They last for a few months and then I am as contented as anyone. Apparently I go along quite smoothly and then all of a sudden something comes over me. I am restless. *I feel as if I had committed a crime.* One section of my mind appears to be fighting the other section the whole time. The first thing that strikes me is that I am going mad.

"I am a Roman Catholic. You know what confession is. All my trouble started over going to confession. I was about fourteen at the time. I got it into my head that all my confessions were bad. It seems to me that there were details in my past life I did not know were sins. When I looked back over these periods I began to think they were sins. This trouble developed until it got me into my depressed state. Have I made it clear?"

ANALYST: "You have not made it at all clear! What, for instance, were the sins?"

"Well, as a kid I used to play around with a little girl next door. I thought nothing of it and had forgotten these things until the age of fourteen when I was confirmed and had to go to confession. Then these molehills became mountains.

"The curious thing is that although I went to the priest and confessed all these things—as it were put all the mountains on to the priest—nevertheless, I did not seem to have eased my burden in the slightest. On the contrary, I felt weighed down all the more. My worry grew greater and greater, with the result that to go to confession became something terrible. The burden that arose in my mind was greater than I could bear. So you see, doctor, even as a child I got into this morbid nervous state."

ANALYST: "The confession should have relieved your mind. Can you make any suggestion why your burden was increased? Was it that your confession did not seem to you to be satisfactory?"

"That was it. I came away from every confession feeling as though I had made a very bad confession, as though I had failed to confess anything that really mattered and yet, try as I might, I could think of absolutely nothing more to confess. Isn't it absurd that such a feeling should have obsessed me in spite of all my efforts to rake up every single crime of my early infancy?"

ANALYST: "We must take the feelings as 'true' and the truth as irrelevant. What are the crimes which your feelings of guilt suggest to you?"

"Now you put it in that way, it occurs to me that about that age, fourteen, and after, I did have some crazy, morbid thoughts. You see, doctor, in the village where I lived there had been one or two girls who had had illegitimate babies, and in our community this was alluded to with bated breath as though it was the most terrible thing that could ever happen in this world.

"Somehow or other—I cannot explain how—this affected me most terribly. Now I can see why: it was as though I were responsible for all these pregnancies and perhaps for all the pregnancies in the world, though to tell you the truth I had never so much as made the slightest sexual advance to any girl in my life, apart perhaps from some childish curiosities."

ANALYST: "And did you confess all these things to the priest?"

"How could I confess' them? They were not true. It would not have been speaking the truth to have said anything of the sort."

ANALYST: "But after your confessions you were left with the guilt-feeling as though they were true."

"I admit that my trouble was that I always felt that my confessions were inadequate, and yet try as I might I could think of nothing more to confess. The consequence was more terrible than I can possibly express to you. I felt sometimes that as a result I was doomed to everlasting punishment."

ANALYST: "What a good time you must have been having—that is to say before this terrible retribution took possession of you!"

"Good time! I do not know what you mean. I was having the most terrible time. This was the time of my nervous breakdown and of this acute depression-madness—soon after the age of fourteen. I do not understand how you can call it a good time."

ANALYST: "You do not understand it at present because you are now in another recurrent phase of depression, but in the periods when you are normal and well and happy you are then having that same good time all over again. That is why you have the attack of depression as retribution all over again."

"What is the good time you alluded to?"

ANALYST: "Why, you had evidently made all the girls pregnant. It must have been highly gratifying. Perhaps there was no necessity for your self-reproaches and retractions, for I can tell you on good authority that all the little girls thoroughly enjoyed their manifold pregnancies. Every doll they received occasioned in them no cause for self-reproach but only for greater delight. The trouble was you did not confess these things to the priest."

"I never thought of that before! You mean to say that is why my confession seemed to me so inadequate? And is that why my depression phases seemed to follow so incomprehensibly, especially after a happy period of elation? I seem to see something in it now.

"Do you think, doctor, I shall go mad?"

ANALYST: "What is the thought in your mind?"

"Well, I know that I am sane at the moment. For example, I know that if I were ordered to drop bombs on Germany I would do it with the greatest relish—I would even enjoy myself, flying an aeroplane and dropping all the bombs that could be

manufactured into German cities—killing as many Germans as possible.

"I could go on doing this with relish. It would do me good, but, *and this is the point*—when the war was over I would never get over it. My crime would come home to roost. I would be in a more acutely depressed state than I have ever yet experienced, and that is saying a good deal."

The significance of such casual remarks as the above must never escape the analyst. The patient has told us in a nutshell the psychopathology of his illness.

His primary impulses first obtain their release and gratification in the symbolic form of flying an aeroplane. His early aggression and sexual aggression obtain in symbolic forms their gratification. He drops his bombs—his libidinal explosions—anal and genital—into the defenceless body of the enemy "objects", moreover, into its "cities", and with it he experiences a period of satisfaction—good health, or even elation.

But when the "war is over", when the orgy is at an end, he goes to confess without confessing the crime, as after all it is only a phantasy and not a reality, and the penance is far more severe than that which any priest would prescribe. It is, in fact, his period of abject depression with suicidal ideas and phobias.

His bombs are now being dropped upon himself. Thus we see the positive libidinal drive and its negative recoil both expressed in such a casual remark by a patient under analysis.

A few sessions later this patient brought me the following dream fragment: "I met an old friend of mine whom I have not seen for several years. I shook hands with him and asked how he was getting on. I appeared to be quite delighted at seeing him."

As this patient has never before brought me even a fragment of a dream it might at first seem disappointing that this dream should contain so little. However, as with all analytical material, dreams, symptoms or fantasies, it is not the part that is expressed and revealed that matters. It is always that which is unexpressed that contains the key to the whole situation. When asked to give his association of thought regarding this friend he said: "He was an exceptionally good footballer." (Pause.) "I think I heard about him lately. I heard that he was in gaol at the moment."

ANALYST: "*What for?*"

"He got mixed up with the I.R.A. I do not think he had

actually done anything, but on account of his associations he was under suspicion so they shoved him into clink."

ANALYST: "*Your depression phase is nearing its end. You will soon be quite well again.*"

"I think you are right, doctor, but I do not see how you made that out. I would like to know."

ANALYST: "*Well, you have met your footballer so he is evidently out of clink. The period of depression is over.*"

"Ah, yes, I know it is over, but how did you know?"

ANALYST: "*Who is your exceptionally good footballer?*"

"My old friend, but really I am not at all interested in him."

ANALYST: "*What are you interested in?*"

"Myself. My condition."

ANALYST: "*And what is that?*"

"It is, or was, one of utter depression. For several weeks I have not been able to take an interest in anything, not even in my wife. I have had no sexual inclination for six weeks."

ANALYST: "*And in the night, just before you had this dream, your sex inclination returned and you had intercourse with your wife.*"

"Yes, that is true. Now how did you know that?"

ANALYST: "*Your dream told me that the exceptionally good footballer was out of clink. You met him and were delighted to see him. I may add that I have been delighted to see you getting better, but if at any future date you should feel that the 'exceptionally good footballer' is again under suspicion, whether he has been engaged in 'I.R.A.' activities or not, I should be glad if you would return so that we may investigate and clear up these suspicions and obviate the necessity of going to clink even for so short a period as six weeks. You see, clink is very uncomfortable, and besides there is always the danger of the condemned cell and that horrible dread of capital punishment.*"

The time allotted for the session was over. The patient seemed to understand. He got up, shook me warmly by the hand.

Psychopathology: The primary nature with which God endowed this attractive and handsome young man was perfectly normal and healthy and innocent. In obedience to forces surging through him he, in his infancy, behaved as he did and found the behaviour pleasurable, exhilarating and health-giving.

His was a happy infancy and a happy childhood. Whatever sexuality entered into it hardly deserved the name of sex as we adults conceive it. Whether it was the roundabouts or swings,

dolls, toy soldiers, cannon, or anatomical differences between the sexes, it made no difference. It was just the pleasure urge of a healthful vitality.

Then at fourteen two things came along. One was puberty, Nature in earnest driving him towards a fulfilment of her purpose. The other was the priest—his confirmation and the confessional—telling him according to his limited understanding that Nature's purpose must in no wise be entertained, *not even in phantasy*.

True, it implied that this might at a subsequent date be tolerated under the auspices of blessed matrimony, but the unconscious was unable to appreciate this subtle distinction. It understood one thing, and one thing only: namely that the voice of God, which had hitherto been the voice of Nature, was now the voice of the Devil and that to hear it at all would incur everlasting damnation.

This damnation occurred, and has recurred periodically throughout the young man's life. It is called attacks of recurrent depression.

Moreover, self-examination, though here an unconscious process, was not limited to the present, it included a re-examination of the hitherto innocent past. Within that past it unearthed all the pleasure-phantasies of infancy and imbued them with the recently discovered guilt-feelings. In consequence the games of childhood, however freely enjoyed at that time, now assumed the evils of forbidden ecstasies. He could not even confess them—for he did not know what they were!

But the condemnations which they exacted became for him a real emotional experience. "The exceptionally good footballer" was shoved into "clink";¹ and as all his vital and pleasure-giving urges were his "footballer", the patient was living during his depressive phase a phantasy of utter castration, the full conscious equivalent of which could only be death. Hence his fear of madness and his phobia of suicide.

¹ "This row of stews in Southwarke.

"... Then next is the Clink, a gaol or prison for the trespassers in those parts; namely, in old time, for such as should brabble, frey or break the peace on the said Bank [Bankside, Southwark] or in the brothel houses, they were by the inhabitants thereabout apprehended and committed to this gaol, where they were straitly imprisoned" (Stowe's *Survey of London*).

It is of interest that the unconscious always chooses the right word for the expression of its meaning.

The full realisation of these morbid mechanisms, particularly of their earliest incipient origins, might well have freed him from their recurrent domination over his affective or pleasure life. Such a full realisation would have entailed very many months of continuous analysis. This was hardly practical on account of war conditions and his Service obligations.

Nevertheless, by interpretation it was possible for him to obtain a sufficient degree of insight to tide him over his immediate difficulties and to induce the realisation that, given sufficient time and opportunity, the problem of his recurrent depression could and would in due course reach a final solution *in life*, and not in death.

However, the psychopathology of the depressive state has deeper roots than those here revealed, and the following short clinical excerpt may help to show us a little more of its depths.

A man of forty-five complains of a state of chronic depression with exacerbations. A momentary glimpse of him at my front door revealed the diagnosis. It was apparent in his face, his stance and in his every movement, even before one had had an opportunity of hearing his retarded speech.

His *conscious* reason for coming for treatment is, as he puts it, because he finds himself temperamentally unable to come to a decision regarding any important matter such as engagement, marriage, the setting-up of any business, or the signing of any contract. Even the question of removing from the house in which he was born is impossible for him to decide. Therefore his life is held in a sort of perpetual *status quo*.

The few tentative attempts at any love life have similarly moved so slowly as to be for all practical purposes stationary. He has had the same girl friend for upwards of twelve years without even an official engagement. She has pressed for marriage, but he says of this: "I am afraid that *when it came to the point* I would be overcome by panic and rush out of the church. I dare not risk it."

Though he thinks his sexual potentialities are normal he has never performed the sexual act, nor, indeed, does he indulge in masturbation.

His earliest memory is that at the age of ten years he became terrified at a picture representing Hell which he saw in York Minster. He was convinced that the slightest sin on his part

would result inevitably in his being relegated for evermore to the eternal flames. *The rest of his young life seems from that moment to have been occupied in watching that he committed no sin.* This is more or less still his psychological position. Only by maintaining this precautionary vigilance and in addition avoiding any commitment does he escape attacks of acute anxiety.

What sin could it be that so upset this patient at such an early age? What could have made him put his whole energy into the repression of "crime" and so produce the crime of repression?

Had he been fourteen or fifteen years of age when the picture of Hell so terrified him one might have concluded that he had been indulging in sexual phantasies probably accompanied by masturbation. Such a conclusion would not have been disproved by the fact that he had no recollection of such a thing. Clinical experience shows that an amnesia (memory blank) of this sort, far from being evidence against the happenings, is further proof of the great degree of anxiety attaching to their memory and thereby causing their total exclusion from consciousness. It is as though he dared not remember such matters.

What he does remember only is the negative side of these things, namely, the great fear of the eternal flames. This fear was great enough not only to stop all sin (*i.e.* sexual indulgence or phantasy), but even to stop libidinal sublimated gratifications in the form of life's gratifying activities—not only thoughts of engagement and marriage, but even every important business or financial transaction. Thus we see that the arrest of sexual life, if the arresting force is sufficiently powerful, includes the arresting of all life in the sense of its sublimated libidinal activities.

Any tendency for his libido to escape either along its primitive paths or even in its sublimated forms arouses such intense anxiety that it is immediately driven back. The net result is that his "life" (*i.e.* libido) is, as it were, incarcerated in a prison or tomb. Life is buried alive. The prevailing mental and emotional tone is depression. When instinct is frustrated depression is the inevitable sequel. Anxiety is the agent in causing instinct frustration. This anxiety is occasioned by threats of super-ego vengeance.

The psychopathology of the depressive state is that it is the conscious form of a general condition of instinct or id-repression.

But our clinical evidence shows us an even more surprising psychopathology than that above detailed.

Undue repression of sexual urges can and commonly does lead to a state of anxiety alternating with periods of mild depression.

In the genuine case of even borderline melancholia the origin of repression of instinct can be traced back to a much earlier age than that of genital sexual activity. It takes something earlier than sex repression to produce the characteristic facies of the melancholiac. Amazing as it may seem, psycho-analytical evidence would fix the repressive process at a level of emotional development corresponding to the second half of the first year of life.

It is as though the infant encountered a hostile world or perhaps had some experiences which induced in him the phantasy of a hostile world, a world which hated his instinctual pleasure urges, at that time predominantly at the oral (mouth) level of gratification. Up to then he had identified himself with his pleasure urges, but now it seems he had to begin to take cognisance of this external world and to identify himself with it.

Psycho-analysis expresses this by saying he introjected this external object into his ego. Thereby his psyche formed a super-ego almost entirely of introjected hate. Such a super-ego, or conscience, will be forever reproaching him for any and every libidinal or pleasure-seeking drive, in short, for every instinct urge.

Thus his instincts, the source not only of pleasure but of his very life itself, are constantly under the inhibiting reprimand of an uncompromising conscience. He lives as it were, if life it can be called, under the tyranny of a severe super-ego. This repression applies not only to his sexual instincts, or to their recrudescence at puberty, but to any and every pleasure-seeking impulse or phantasy.

He has a sense of unworthiness, for his super-ego is everlastingly hating his ego in so far as it has even become cognisant of the desires or impulses of his instincts. His ego, attempting to obey the behests of this tyrant, redoubles its efforts to repress his emotional life.

As a result there is not only emotional loss, but also paralysis of action, thought and feeling. There is, for instance, such a paralysis of the ability to love that it is small wonder that he

cannot make up his mind to marry. The burden of the miserable life, or lack of life, enforced upon him by this over-severe super-ego is shown in his miserable expression.

Is there no relief which such a sufferer can obtain? Must he remain so tortured, year in and year out, decade after decade, throughout his life?

In many cases nature provides recurrent intra-psychic relief. The repressed or imprisoned instinctual life periodically and temporarily gains mastery over the repressing super-ego. Patients who exhibit this phenomenon periodically throw off their depression and for the time being give vent to their instincts without guilt.

The super-ego has been silenced. Psycho-analysis says it has been "swallowed". They have a feeling of zest and energy which appears to be a return of feeling, but is really elation, the counterfeit of feeling. If this phenomenon is at all marked they are then said to be suffering from an attack of *mania*.

It is not every case of depression which alternates in this manner with periods of elation. In many cases, such as that of this last patient, the state of depression seems to be almost constant, though there may be fluctuations too slight to be at all striking to the casual observer.

Perhaps enough has been said to show that the deepest roots of the depressive state are very deep indeed, and in melancholia hardly accessible to ordinary psychological treatment. Nevertheless, even in severe cases a certain amount can be done, at least in the interim periods between attacks, to give the patient insight into his condition, to make him more tolerant to it and it more tolerable to him.

Cases which are too severe to be accessible even to psychological approach, such as those which are definitely psychotic and suffering from delusions, are sometimes benefited, at least temporarily, by convulsive therapy, though I would stress that, as we might expect, this benefit is more of a symptomatic than fundamental nature. They can become as garrulously shallow in their affective life as they were emotionally dumb during their depressive phase. Automatism, whether retarded or hyper-active, should not be identified with life or credited with feelings appropriate or adequate to a mature human level of evolution and development.

CHAPTER XIX

MANIA

THOUGH relatively not very common, perhaps the most interesting and alarming of all mental manifestations is that of acute mania. The maniac is popularly considered to be the typical madman.

While medical and mental science regards mania as coming entirely from within the organism (endogenous) and disputes only as to whether its origin is chiefly from the body (endocrine imbalance, etc.) or from the psyche, the popular point of view on the other hand clings to its conception of people being *driven mad*, for instance, by the pressure of external circumstances.

The Maniac: Now this is a case where it would seem, at least from superficial observation, that circumstances were the essential factor responsible for the outbreak of acute mania. These circumstances may be of particular topical and popular interest in that they were those of the most tragic event in the whole history of the first two years of the war, namely, the debacle of France's collapse and capitulation.

Unlike some of his less loyal compatriots, this Frenchman was devastated at the spectacle of surrender to Germany and alienation from England. He just could not take it lying down. It was clear to him that all the French colonies must immediately break away from a traitorous mother country, and throw all their resources and their populations into the battle for England and the restoration of a free France.

His official position in Syria enabled him to gain interviews with various leading politicians and generals, but, try as he would, he felt he was not succeeding in firing them with his enthusiasm. The more he was brick-walled by officialdom, the more vigorously and frantically he pitted himself against these
ing barriers. Nobody actively opposed him. It was just inertia which seemed to call him to greater and more
ate efforts. He chartered aeroplanes and flew from one
to another, trying to arouse in others the enthusiasm which

was consuming him. He grew more and more excited. There was no time for adequate sleep.

Finally he broke down entirely; went raving mad; had to be locked up in a room in a mental hospital. There his behaviour was characteristically maniacal. Still, apparently feeling that there were barriers which he had to overcome, he beat his chest against the foot of his bed until he was a mass of bruises.

It was some months after this that he entered my consulting-room. I saw a rather plump, round-faced, short-necked man—a very English-looking Frenchman. (I learned afterwards that his mother was English.) He was no longer elated and excited; on the contrary, calm and self-possessed. He complained that he felt very *lazy*, that it was a great effort for him to do his work.

"I can't be bothered with anything, doctor; that is what worries me. If I try to read a letter, I lose interest before the first paragraph. I can muster no enthusiasm about anything. It seems I just don't want to be bothered. I don't think I am doing any good; I'm not capable of any useful work. I am absolutely bone lazy. I don't want to do anything. Everything is such a confounded effort; that is my complaint."

"Yes, I must admit that this is in complete contrast to the state of wild enthusiasm which led to my breakdown. At that time I was one seething mass of restless energy. My enthusiasm was unbounded."

ANALYST: "*At that time you felt you might get something big done; you might work an international miracle.*"

"Yes, that is what I felt at first, and I was elated and wildly excited. Nothing was further from my thoughts than that I was on the verge of a breakdown. Overnight I found that I had taken the centre of the stage. I felt I had a great mission to fulfil."

ANALYST: "*And what happened when you discovered that your efforts were getting nowhere?*"

"That is when I went mad. At the time I had no idea that I was going mad. I felt tremendously well and confident. I suppose my enthusiasm was such that it simply would not take failure into account. It was then that I decided that God was on my side; that France could not perish; that with God's help I would win through, and everything would come right. Apparently my faith in man could not be maintained, so I simply pinned it all on to God. I kept the faith. Presently an extraordinary inner

humility came over me, but it seems that it was humility to God only. It did not hamper my fervid activities. I sent a telegram to the Head of the State. It started with the words: 'The Lord grant faith and humility to all the servants of France'. The telegram amounted to a religious exhortation, an attempt at a sort of lightning religious revival. At the time I thought it extraordinarily appropriate. This religious business got me more and more. Instead of sleeping I read Isaiah all night. I felt in a high state of religious exaltation. I was never more sure of myself or more sure that I was doing the right thing.

"A man came to see me—a doctor, I suppose—and I remember that I said to him: 'When you knock on the door of God, don't do it timidly but knock like this.' I seized a chair and beat the door down. Then I turned to the man and tapped him with my foot, and finally I was taken off to a hospital. There I believe I had a period of complete unconsciousness." (This was evidently a phase of stupor. Its rapid onset is of good prognostic significance.) "I suppose as a result I was left alone for a time. They must have thought I was a quiet patient. When I came to, I got the idea that I must mutilate myself and inflict physical pain upon myself for *God's sake*. That is why I started throwing myself against the end of the bed. It hurt me, but I felt God wished me to keep it up.

"It seemed to me to be a supreme trial that I must keep up in order that France might triumph. When I was severely bruised and the pain of continuing became very great I was anxious that somebody should come and stop me. I got the idea of banging myself on the door. It seemed to be a message that I got to do this so that somebody would hear and stop me. But that message I rejected as a temptation of the Evil One; that is to say, not the genuine article from God.

"Suddenly I got the idea of banging my head on the stone floor to knock myself out. I was about to do it, and in some miraculous way I arrested myself in mid-air, for the thought came to me that I might do it too thoroughly and kill myself, and I did not want that. There was in my mind the idea of crucifixion. Perhaps I thought I was being like Christ and crucifying myself to save France.

"Apparently the whole illness only lasted a few weeks. I don't know whether the depression I now suffer from comes from the fact that I am now not so sure about this religious faith. Any-

how, I am not at all satisfied with myself. I have a feeling I am not doing a good job of work. Should I go on just sleeping because my inclination is to do nothing?

"I feel what a terrific bore life is. I get these fits of depression for which I can give no reason.

"At that time I seemed to have a message from the Almighty and a great mission to perform. My depression I think now comes from a sense of frustration. I find everybody around me just carrying on very much the same as though it were still peace-time, as though there were no war on, no terrific crisis that demanded one's uttermost effort and enthusiasm. It seems that my enthusiasm can no longer cope with this state of affairs, so, it seems, I just give it up. I have lost every atom of energy, and can't even be bothered to read a letter. Is it that I have surrendered to circumstances? Given up the ghost? Perhaps I have lost my faith in God."

At the next session this patient brought me a dream:

"I dreamt of a house on a hillside. It was surrounded by fir trees in a square. One fir tree in front was dead, dried up.

"I suppose it may have had something to do with the house I lived in when I was ten years of age. Or it might be a villa in the South of France where I went on holiday. I had my first wet dream while staying at that house.

"If the sexual side is at all important, doctor, I might as well tell you that for some time past I had felt I was not as sexually active as was desirable or normal. I have always been more concerned to satisfy my wife's feelings than my own. My dissatisfaction with my own absence of sexuality comes back to my feeling of incompetence in general. If only I could have got the French authorities to do something instead of nothing! There is a sense of acute disappointment, a sense of failure on my part. I avoided this reaction at the time of the crisis by putting my failure down to unworthiness and by enlisting myself in the service of God. Now that that has all gone I seem to have nothing."

Psychopathology: I would not presume to judge between the weight of medical opinion and the public idea in the aetiology of manic-depressive psychosis. Cases are constantly being met with in which the maniacal attack appears to have no external cause whatever. Many individuals are born with the cyclothymic

temperament, and throughout their lives are prone to periods of recurrent exaltation and depression. Perhaps we are all in some degree subject to these alternations of temperament without any apparent external factors causing them.

Many and diverse theories have been advanced to account for this strange state of affairs. One could almost grade them from the chemico-physical at the bottom of the scale to the purely psychological at the top. None have as yet been definitely proved or disproved. Amongst the psychological theories alone there are some interesting variations. Whereas some regard the manic phase as fundamental and the so-called depressive phase as merely a rest period, sometimes years in duration, between the manic outbreaks, others, on the other hand, of whom Freud is one, regard the depressive phase as fundamental, and the manic phase as a temporary release from the punishing activities of the super-ego. McDougall rightly points out that although there is usually retardation of thought and general slowness in the depressive phase, the opposite to depression is elation, not excitement. In fact, excitement can occur even in states of depression; for instance, in agitated melancholia.

It remains to be added that in certain cases either of these phases may be so slight as to escape observation altogether.

In the present instance we must limit our considerations to such psychopathology as this particular patient reveals. I would like to start at what may seem to be the wrong end, and point out that this individual of Kretschmer's pyknic type was subnormal in his capacity for reduction of tension by indulgence in sexuality. The only dream recorded and his associations of thought to it reveal that his first pollution dream was coupled with outstanding castration symbolism. The dead fir tree and associative material show us that sexual relief is strongly identified in his psyche with something intensely unpleasant and unhappy—the death of vitality. Such a psychic disposition would tend to turn the possessor away from sexuality, so that his dynamic energy would be directed more to the activation of psychomotor paths and those of thought and phantasy.

As most cyclothymic individuals show, this dynamic energy is inclined to be supernormal rather than subnormal, so that we may expect an excessive rather than a subnormal degree of mental activity from him. I should add, perhaps, that in many such cases, during the maniacal phase sexual activities, like all

other activities, are incredibly abundant. The individual seems tireless, and carries on day and night until the long-deferred exhaustion supervenes.

It seems that in this case at the outbreak of his illness the rush of energy all flowed into overloaded mental channels and could not be stopped for any obstacles, including those of reality. He therefore simply brushed reality aside, or rather *it was brushed aside for him by the forces welling up within*. No obstacle could be tolerated. Enthusiasm was instinct-driven. It was the vehicle for his mental energy, energy which simply had to be discharged. When the ego is overwhelmed by such enormous forces, and enlisted entirely in their service, ignoring all obstacles and frustrations and realities around it, we have the phenomenon of insanity. Something within the psyche is being gratified, relieved or discharged, and its pressure is too great to brook any frustration, however real. Ideas, no matter how crazy, will be brought into its service, provided they serve the purpose of this perhaps psycho-physically necessary process. Enthusiasm was compulsively maintained, and, in the absence of human co-operation, "God" was enlisted.

He tells me that during this period of maniacal excitement he was supremely happy, in a state of exaltation. This was because the tensions were being discharged. Happiness has been defined as the pleasurable process of tension relief. Not only was tension being discharged, but at the same time it was being maintained at a high level. Perhaps its supplies seemed at that time inexhaustible.

Recovery came about only when these supplies began to fail. The tension became less all-powerful in its demands, and there was a chance for his ego to take cognisance of the realities around him. His affective or feeling tone simultaneously became a very different one. With exhaustion and the lowering of tension he was more like a pricked balloon. He had neither buoyancy nor enthusiasm nor energy. In fact, it seemed to him that life was very flat.

"I feel so lazy, doctor, that's what worries me." Nevertheless, this "lazy" man was now comparatively sane.

It is quite clear that this laziness is the inevitable consequence of the enormous outburst of enthusiasm and energy which so convulsed his system, overpowered his ego, and exhausted itself in those weeks of continuous, hectic, mental activity. We cannot

embark on an orgy of unrestrained spending without becoming bankrupt.

Therefore I advised him to listen to the voice within, which was, through the medium of his feeling, telling him what to do, namely, to rest. In due course his energy reservoirs will refill themselves and he will return to normal.

The problem remains as to whether or not, in the absence of the external stimulus of the abnormal crisis, this psychic cataclysm would have happened.

Although I would admit that he had the cyclothymic temperament and a constitutional predisposition to manic-depressive psychosis, I am inclined to think that in his particular case the outbreak would not have occurred had it not been for the very special stimulus of this crisis. I hold this view because he reached middle-age without any previous attack.

This is as far as a preliminary study of this case takes us in considering the superficial aspects of the psychopathology of mania. According to Abraham (*vide* his paper on "The Development of the Libido", *Selected Papers on Psycho-analysis*, 1927), who has conducted deeper analyses of manic-depressive patients during their interim periods, the essential psychopathology of this psychosis is a fixation of libido at the second oral (or biting) stage of libidinal development, with consequent ambivalence (love and hate) and inadequate capacity for psychosexual gratification with a complete (whole) object-love. The libidinal life therefore remains in large part immature, shallow, and confined to part-objects and narcissism, with outbursts of intrapsychic conflict and inadequate appreciation of reality.

An interesting reflection for the practical psychotherapist is the degree of applicability of this and similar theories in the analysis of minor degrees of cyclothymia, of the neuroses in particular and of personality disorders, character traits and so-called normal psychology in general.

In trying to discover the aetiology of such grave psychoses as mania there will be those who prefer to conduct their investigations along physical and physiological channels, but perhaps they should remember that there are infinite gradations in degrees of cyclothymia so that even the most "normal" persons differ in the degree of sensitivity of their moods to both environmental and endogenous (physical or mental) stimuli. As physiological investigation has as yet not been able to reveal any

definite aetiological factors responsible for the extreme manifestations of mania and melancholia, it is obviously very far from convincing us that our tiniest affective responses to what would seem to be external agents are really nothing of the sort, but are primarily physiologically conditioned.

CHAPTER XX

SCHIZOPHRENIA

THERE is one word of advice for the beginner who contemplates analysing a case of established or incipient schizophrenia—literally one word—it is: “Don’t!”

On the other hand it was held by Bleuler, who first coined this term in 1911, that all functional mental disturbances, with the exception of manic-depressive psychosis, all psychogenic disorders, including all abnormalities of mental make-up, were manifestations of schizophrenia. Bleuler had thus extended and increased the scope of Kraepelin’s (1896) description of dementia praecox. Schizophrenia he described as a morbid process characterised by the “splitting of the mind”, resulting in an increasing withdrawal of interest from the environment (introversion) together with “a disorder of feeling, of conduct and of thought”.

If there is any truth in Bleuler’s view, probably every case, or almost every case, which we analyse has at least a modicum of this morbid process at work within it. Therefore, although it is impracticable to analyse established schizophrenia outside an institution, it is advisable for the would-be analyst to try to understand the essentials of its psychopathology, if only because of the possibility that it has ramifications within the interstices of almost every mind which he will analyse.

Attempts to attribute it primarily to bodily changes, such as those of endocrine disorder (Kraepelin, Bleuler, Mott, Alzheimer and others) or those of faulty metabolism (Gjessing, Lorenz, Levenhart and others), though undertaken with great care and perseverance by a succession of competent observers, have led to a surprising absence of any concrete conclusions. For instance, Dunlap, after particularly careful investigation with schizophrenic cases and control cases, came to the conclusion that previous observers, including Alzheimer, were mistaken and that “schizophrenia is a condition lacking in any fundamental or constant alteration in nerve cells”.

The fact, though a negative one, that no concrete conclusions

in regard to organic or physiological changes can be maintained in our present state of knowledge, is of the utmost importance as evidence that the trouble is primarily psychological, and as evidence of the extraordinarily far-reaching effects that can finally result from psychological processes—if indeed evidence were needed.

Adolf Meyer, one of the chief exponents of the psychological point of view, regards schizophrenia “as the outcome of progressive maladaptation of the individual to his environment”. In his view it is an extreme manifestation of a probable “reaction type”—“the end-result of an accumulation of faulty habits of reaction”.

When we consider in conjunction with this view that approximately half the cases have a family record of mental illness, the aetiological position as between hereditary causes and acquired reactions becomes somewhat complicated unless we revert to a discredited Lamarckian hypothesis that acquired characters may be inherited, in which case we have only to consider this reaction-hypothesis of Meyer's as extending through a succession of generations, to be able to credit it finally with the production of schizophrenia.

It is not possible in the present chapter to go into all the problems of the Lamarckian as against the Weismann theory (of the continuation of the germ plasm alone), but I may mention in passing that this is only one of innumerable considerations which, in spite of the biologists, leads me to regard a total exclusion of Lamarckism as short-sighted. The operation of Lamarckism in some form or another is the only possibility of accounting for not only the production of such disorders as schizophrenia together with all other deep-seated psychogenic disorders, but of also accounting for the essential evolutionary principle of biological adaptation to environment.

In short, Lamarckism pits the evidence of the whole biosphere against the isolated instances of the experimental biologist.

From the evidences of family history it would seem that schizophrenia is a disorder the roots of which lie deeper than the individual, probably affect the germ plasm and are transmittable. In this connection it is interesting to note that many of the physical investigators found, or thought they found, a disordered secretion of the sex glands. My view would be that functionally a disorder of the mind cannot leave unaffected the

function of sexuality, nor vice versa. This is not unrelated to heredity, transmittability and Lamarckism in general. It may be possible to return to a consideration of the psychopathology of this illness after we shall have studied a few examples.

In spite of the formal divisions of the illness into three or four main groups, for instance according to Kraepelin (1) the "Simplex", (2) the "Hebephrenic", (3) the "Katatonic" and (4) the "Paranoid", the impression of the psychotherapist who comes into contact with the borderline rather than with established cases is that there are as many varieties as there are individuals. No two cases are the same, though large numbers of patients may show some element of a morbid process characteristic of or analogous to schizophrenia. Indeed, it might be said that the conception of "mental conflict", the primary factor in all psychogenic symptom-production, is in some degree synonymous with Bleuler's "splitting of the mind". Indeed, apart from debilitating illness such as influenza, it is commonly some current conflict, such as a love affair, worry over masturbation or a sexual incident, which precipitates the breakdown, though it is afterwards discovered that a movement towards it had been going on insidiously long before. The symptomatology varies greatly according to the severity of the particular stage of the illness, but a constant characteristic is some degree of detachment from reality either emotional or intellectual or both. The patient may show natural apathy and indifference with perhaps mild depression and a feeling of failure, or he may be dreamy and full of ruminations with a failure to respond adequately to events around, which should ordinarily cause some affective response. Often a queer disharmony between the patient's thought and his mood can be detected. He may smile while thinking or speaking of something distressing, or less commonly, his eyes fill with tears at something ordinarily cheerful. This is because his emotional response is in accordance with his phantasy life, irrespective of the current distraction of comparatively superficial realities.

At a later stage of the illness there will of course be even more marked changes in his personality, and these may be shown by slovenly behaviour and disregard for his appearance. Sooner or later in a case which is well on the way to established schizophrenia there will be ideas of reference, as, for instance, that people are making actions mocking him, illusions and hallucina-

tions, particularly of hearing voices (*e.g.* commenting upon his secret thoughts), and delusions, sometimes of his outstanding importance. However, his delusions are not systematised as they are in paranoia. In contrast to these grave symptoms, there is relatively no disorientation of space or time, or impairment of memory or intellectual faculties as such, although he is so seriously out of touch with reality.

It has been said that all mental disorders represent stages in a one-and-only mental disorder, namely, disintegration of the mind, or dementia. Observation of advanced cases of schizophrenia seems to support this conception as so large a proportion of them become steadily worse until they are truly demented, and unless mute, display complete incoherence, with the familiar so-called "word-salad".

(1) According to Kraepelin's varieties the schizophrenia "Simplex" comes about insidiously. For instance, a mother has been known to say that her daughter "has not really altered; she has only gradually grown more and more like herself". The general impression of detachment from reality, either emotional or intellectual or both, is accompanied by a lack of ambition and either a general contentment with an idle, unprogressive life, or a hopeless and impractical dissatisfaction.

(2) The "Hebephrenic" variety is also difficult to differentiate, seeming to lie between the "Simplex" and the "Katatonic" types. There is usually, though not always, a history of tantrums or neurotic tendencies, and the introverted individual seems to become more completely introverted, not bothering to go out or perhaps even to rise from the chair. If, however, you can get him to talk, you may be surprised at the amount of emotion that lies under his shut-in exterior. There is often not only emotional disturbance, but considerable incoherence. Hallucinations of hearing and sometimes of sight are particularly common in this variety. There are also abundant ideas of reference and probably a history of a good deal of senseless conduct.

(3) The characteristic of the "Katatonic" variety is an alternation between what is called "catatonic stupor", a usually more pronounced retreat even than that of the "Hebephrenic", and outbursts of an extraordinary excitement. In the dull, stuporous stage the patient will be mute, often with a refusal of food, a vacant expression, and stand like a mummy taking no interest in anything. There are a large number of mannerisms, and in

advanced cases extraordinary symptoms and signs, including signs of bad circulation of the extremities shown by a blueness of the arms and a phenomenon called *flexibilitas cerea*, which means that whatever odd attitude a limb is placed in he will retain it in that position for a considerable time. There may also be such symptoms as echolalia and echopraxia, which mean respectively a parrot-like repetition of what one says to him instead of answering one's question, and a senseless imitation of one's gestures. From this shut-in position the patient may burst into a violent frenzy without any warning and perform any violent act to himself or others. He is not intentionally homicidal but acts impulsively, probably in response to some hallucinations.

(4) The "Paranoid" varieties usually come on considerably later in life. Physical changes are not so marked, though there may be a number of complaints of a physical nature. One of the main features of this variety is delusions, not so systematised as those of paranoia proper. Nevertheless many modern authors have separated this group from schizophrenia and included it under the possibly related reaction-type group of "Paranoia, Paraphrenia and Paranoid Types".

However valuable these classifications are to the psychiatrist practising in mental hospitals, they are not so useful to the psychotherapist who has to deal not with the clear or established cases, but with very minor forms of an analogous if not identical "mind-splitting" process. Farrar's idea of five main types of shut-in personality is more useful to psychotherapy than the orthodox psychiatric divisions into three or four groups characteristic of advanced cases. Farrar distinguishes (1) the Backward Type; (2) the Precocious, Studious Type; (3) the Neurotic Type; (4) the Asocial, Seclusive Type; and (5) the Juvenile Type. The psychotherapist is all too familiar with the difficulties presented by each one of these various introverted types, if indeed he does not in some cases completely miss the essential relationship of his patient to this disease. To illustrate this I will first give a few brief instances of patients who have been sent to me for treatment and then a longer case history of a patient who though not schizophrenic in the asylum sense can be classified only under that category.

The first case is one which belongs quite clearly to Farrar's "Juvenile Type". She is a woman in the early thirties who looks

so young that she is frequently being humiliated by being taken for a child. For instance, going with a party to a licensed hotel she was refused admission by the proprietor, who would not be moved! She was sent to me because she was getting very depressed and weeping in her home atmosphere, complaining of a general lack of interest in things, was nervy and irritable with a show of tantrums.

When she saw me she had very little to complain of except that she had lost confidence in herself (though it transpired that she never had had any confidence), that she did not seem to do anything right and was usually rather depressed.

She said: "I seem to be very little use, and there does not seem to be much object in my living at all."

She later admitted that there was nothing new about this, as ever since the age of fourteen she had always wondered why people were born or why they went on living. She found life far too much to cope with and particularly avoided all social contact, and indeed contact even with relatives or friends. Her slow method of thinking and speaking gave the impression of stupidity, and one might have confused such a case with a high-grade mental defective, but the fact was that this young woman had had a high standard of scholastic education and was indeed a university graduate!

My justification for placing her tentatively under the heading of borderline schizophrenia of Farrar's Juvenile Type is partly because her emotional life was confined to day-dreaming and that she had, in all emotional relationships at least as well as in many other ways, retreated from almost all reality contacts. Even this dream life she had not made fully conscious and certainly had never mentioned it to anybody. It was some time before it emerged. It proved to be an extraordinary saga of the romantic-novel type of adventure. But even there she herself was not one of the characters in the romance, although it was noticeable that the heroine bore her name! The chief adventures of this heroine were those of romantic marriage and reproduction. Hero and heroine became the parents of a family, the family grew, and one of the daughters, in turn with a name like her own, would marry and in turn reproduce, and so on with much detail throughout many generations. This dream life was her sole form of recreation.

These dreams contrasted markedly with her reality behaviour,

for emotionally, bodily and in time and space she always closed up and backed away hurriedly from any and every eligible male contact. Indeed, she was totally unaware of any sexual inclination throughout her life. Nevertheless the relating of her dream sagas, which had been going on unspoken for over a decade, apparently set things moving within her, for she duly became conscious of what appeared to be normal desires for love and sex. At the same time some improvement took place in her social life and sociability. Though she has since gone abroad in the hope of marrying—a hope backed by some real libidinal desire—and although she indulges in erotic phantasies, some of which are accompanied by complete sexual orgasm, my knowledge of her psychopathology makes me of the opinion that she would in sexual congress suffer from frigidity, and that further improvement would be difficult to achieve. Persons who have failed to grow up by the time they are well over twenty may well be the despair of the analyst.

Her psychopathology may throw a little light upon that far more advanced condition called Schizophrenia Simplex. The lack of ambition from which these patients suffer was common to this girl also before she came for treatment, and analysis revealed quite clearly that this lack of ambition was due to *lack of libidinal drive*. It revealed also that the reason for this lack of libidinal drive was because her libido, instead of overcoming the inhibiting effects of parents and family, had either remained inhibited or had regressed to a childish or infantile level. Her emotional age, which was still that of about thirteen or earlier, represented a stage when, with the onset of the menses, she had violently repressed all sexual thoughts and feelings from reaching consciousness or achieving any further degree of maturity.

At one stage in her analysis, when she was for the first time becoming conscious of sexual feelings, she dreamt that she was running away in a car from a riotous mob which would have seized and destroyed her. In association of thought she said: "If I had not come for analysis the sexual feelings would have been held in check, and then there wouldn't have been all this rioting business. When I first came here I had some idea that you'd help me to get rid of my day-dreams because I couldn't control them any more and they were getting more and more hold over me and overpowering me more and more, so that I seemed to have lost all interest in everything else in life."

This may cause us to reflect as to whether "Introversion" is really synonymous with unconscious sexual phantasy, and as to whether this is the essence of the initial movement in schizophrenia.

Later this patient said: "In getting away from the riotous mob I was trying to get back to mother and father. I have felt that I should never have left them for a moment. That's why I wanted to get rid of the day-dreams too. I felt like a child who had walked out of a nice comfortable home to see what the night was like and couldn't find its way back. I used to depend on mother and father for a comfortable background, and I suppose for comfortable feelings. The day-dreams were a compromise—half and half—but the riotous mob was terrifying. Instead of getting rid of my day-dreams this treatment has brought up something worse."

Evidently her case is an extreme example of the familiar conflict between developing sexuality and the primitive and repressing fixation to parent imagos. As she says, the day-dreams were the introverted compromise between the two sides of the conflict, absorbing almost all her libidinal energy and her life. The resistance to mature sexual development and extraversion is evident.

It may be suggested that in this case some hypo-function of the pituitary could account for both her childish appearance and emotional anaemia. Though I would not deny such a possibility, I still think it is unjustifiable to assume that such hypo-function must be primary (perhaps magical) and (if present) that it cannot itself be secondary to emotional retardation psychologically initiated.

Analysing such patients, whether or not they may be regarded as on the outer fringes of schizophrenia, may well throw some light upon the nature of schizophrenic mechanisms which it is often impossible to trace in more advanced cases of the illness. When we get to a slightly more schizophrenic case than the one just described we are apt to meet with technical difficulties during analysis.

For instance, I have had patients who, lying on the analytical settee, and showing the usual vague ideas and affects of the schizophrenic, suddenly developed disorders of conduct—while one was still trying to see rhyme or reason in their rather intangible but interesting mutterings. One such patient, for example, would refuse to leave the consulting-room at the end

of his analytical hour, it commonly taking ten minutes or more to persuade him to make way for the next case. If he did rise from the settee he would then stand in a catatonic attitude in the middle of the floor, silent and impervious to words or attempts to lead him out. Any attempt to draw him by the hand or to push him gently or firmly resulted in a stolid mule-like resistance (*Negativism*). I soon overcame this difficulty by making him the last patient of the day and leaving him alone in the room to find his own way out, but in due course he learned to anticipate my departure, and I would find him holding the handle of the door of my car, necessitating similar delays and persuasions on the pavement outside. He admitted during the sessions that he was again a baby clinging to a much-needed mother, but the splitting of his mind was such that these and several more extraordinary samples of insight made little or no difference to his actual conduct. Though analysis had to be stopped on account of such difficulties, I may say that for over ten years this patient has avoided the need for mental hospital treatment. Nevertheless, the reason I would advise against treating any established schizophrenic case is that however quiescent, "Simplex" or "Hebephrenic" they may appear to be, there is, until we know our patient very well indeed, the danger of an outburst of catatonic frenzy—for which the analyst may be unfairly blamed.

Against this I will give a short example of a fairly typical hebephrenic in whose case I found it helpful to establish a transference in order to gratify her parents' wishes that she should be persuaded to have convulsive therapy without having to be certified or enter a mental hospital. The following are her remarks at the first interview recorded verbatim.

She says: "The chief trouble is that for a long time now everything I do or think seems to cause some commotion and there is always a lot of talk about it. If a memory comes to me, it seems to bring some voices making a remark about it or repeating it. Sometimes it seems to be shouted about the place."

ANALYST: "*How long has this been going on?*"

PATIENT: "Over two years. It began with influenza and a general breakdown which I had. It has been up and down ever since. I have had it brought to my mind by voices or whispers. If I get a pain it is remarked about by voices. Some are men's voices and some women's voices and some the voices of children.

It is so difficult to express. It is so real and disturbing and tormenting. Very often mad things come to your brain and you do not want to be tormented by them afterwards."

ANALYST: "*What mad things for instance?*"

PATIENT: "It is mad to think that the next-door neighbours are listening-in to my brain."

ANALYST: "*Do you mean that they are really listening-in directly to what your brain is doing?*"

PATIENT: "I don't know. I cannot help feeling it because of the repetition I hear and the discussion afterwards. I have tried hard to think it is just imagination, but I cannot. It seems someone's got a *plan* of my brain and as different parts of me work so they know."

ANALYST: "*For example?*"

PATIENT: "If I scratch my neck I hear it repeated, 'She's scratching her neck.' The last few days I have had an irritation of my back passage and when I have been in bed scratching it I have heard remarks about it. Sometimes the voices are my neighbours, sometimes other people I have met."

ANALYST: "*Do you think it could be a part of your own mind doing this?*"

PATIENT: "No. I don't think so. I don't think it is my own mind. It is different voices and some of the voices I do not recognise. It makes you feel so hopeless. It has been the same for eighteen months and it is most embarrassing sometimes. For instance at my period every time I put on another towel there has been talk about it, even shouting about it. I have tried to get hardened to it, but I feel it should not be. Sometimes I let off some curses." (She has been known to run out of the house and reprimand the neighbours volubly from the street—a performance which, of course, everybody failed to understand.)

She continued: "It is irritating to feel that people somewhere know what you are doing. Also in bed I get a feeling of pressure as though people are over me doing things to my body. It is horrible to think that they can give me pain in my eyes or head and that I can keep nothing to myself that is private. It is like a wireless set in my head that anybody can pick up. Sometimes I have heard three different voices; one telling me not to do a thing, the second telling me to do it, and a third, which is my own voice, steering in between the other two."

This is clearly a case of schizophrenia of the hebephrenic type.

Her history shows that she has hitherto had no outbursts of catatonic excitement except perhaps of the very minor degree of her rather emotional outbursts reprimanding her "tormentors". I may add that after a few sessions this patient, contrary to what many suppose happens in these "narcissistic" illnesses, showed signs of a considerable degree of transference and was completely obedient to my advice, attending for some eighteen bi-weekly electric convulsive therapy treatments. Fortunately she was one of those who showed an appreciable degree of improvement. The voices grew fainter and more distant with almost every shock. What was left of them she easily learned to ignore and was able to take up some part-time work. But they never completely disappeared. It took a bomb explosion which buried her under the debris of her house, from which she was dug almost suffocated some six hours later, to effect the final and apparently complete cure. Every vestige of her hallucinations vanished from the moment of recovery from that last experience. However, in a case as pronounced as this, one would be wiser to regard the apparent cure in the nature of a remission brought about by shock and not to be surprised if the illness recurs even after many years of relative normality.

Looking for a patient who may throw more light upon the psychopathology of the schizophrenic process and be able to correlate our findings with those of the psychopathology of neuroses in general, I think of a man in the middle forties who, though not so typical a schizophrenic as the previous case, is undoubtedly very introverted and narcissistic and whose conduct has been such that he could hardly be placed under any other classification than that of a borderline schizophrenic. He is now approaching middle-age and is, or rather was, a university lecturer, which gives some idea of his intellectual attainment. His interests are very academic and he is liable to waste endless days and weeks discussing learned metaphysical obscurities instead of the relevant material for which he has come for analysis. He is scholarly, well-bred and with a gentle and emotionally neutral disposition. He has become particularly interested in a succession of cults, such as occultism, and has periods during which he starves himself for idealistic reasons. He is impervious to emotional disturbances around him to the extent even of appearing emotionally detached.

With all this gentleness, so common in the schizophrenic

reaction type, his history includes behaviour which characterises schizophrenia or the schizoid character. For instance, though moderately wealthy, he has spent months as a disreputable tramp leading a nomadic life and sleeping in gorse bushes and open fields, winter and summer, getting soaked to the skin and letting his clothes dry on him, going without food and getting frequently taken up by the police as a suspicious character. Twice he has been placed in a mental hospital, diagnosed as schizophrenia, and certified. He has indulged in other behaviour totally incongruous with his intellectual attainments and social position. He has gone in for stunts such as scaling scaffolding on buildings to great heights, walking through rivers up to his face in water, jumping on and off trains, running round and round a London square until he dropped and was picked up by the inevitable policeman; and once he tried to board a bus in Piccadilly by levitation. He broke his collar-bone and got himself into hospital. But he did not complain of these things. He complains of what he calls a "lack of spontaneity" and a "lack of feeling". He says he is quite incapable of spontaneity and of emotion, and some of his behaviour at least was evidently with a view to "*forcing himself to be spontaneous and to feel some emotion!*"

At his first interview he told me that he felt the absence of any guide from within to tell him how to act as other people acted, particularly in regard to the opposite sex, but this lack of spontaneity included any and every form of behaviour. In its absence he had no other course but to direct his behaviour with his ego as there were apparently no instinct urges to prompt him. He said the only way he could live was to go through the motions of living, copying those which other people appeared to do. It was not very satisfactory as it was a continuous effort, brought no reward, and somehow or other he always made a mess of it.

It was not easy at first to get him to give particular instances. When asked for an example he would say:

"My trouble is as soon as I put one foot on the accelerator I jam the other on the brake. In any case I have no feeling in the matter. I do not even feel real in myself. I simply must do something about it."

It later appeared that what he had been "doing about it" was trying to accost young women whom he saw in public places. Apparently his object was not that he wanted to get to know

them or necessarily to have any relationship with them, but simply that he felt it his duty to himself to force himself into this form of activity principally because he had no real inclination for it! When I insisted that presumably there was an inclination of some sort, he finally admitted that his only inclination would be to retreat and to retire into solitude, but manifestly that was no good, that is what he had done all his life and it had got him nowhere and never would. He used a metaphor which cannot fail to be symbolically interesting to the analyst. He said:

"My Jack has been shut up in its box. All my life it has been shut up. That means that I have not lived at all, not yet. I have never felt any real emotion. I simply *must* let it out or *make* it come out or I might as well be dead now."

Apparently this accounts for, though does not fully explain, some of his stunt behaviour. When asked when his Jack became so completely and permanently shut up he immediately referred to an incident at the age of five years. He said:

"A little boy and girl were brought to play with my sister and me. I took an aversion to the boy, but I fell for the girl. I therefore left the boy with my sister. I was having a glorious time with the little girl and I was so engrossed in playing with her that I did not understand my sister's shrieks and yells. Either I did not understand or I chose to take no notice. The little boy had been ill-treating my sister. My mother arrived on the scene and went for me about it. She said I was the oldest and she expected me to look after the others and I had betrayed her trust."

As is usual in analysis the first reference to a traumatic incident proves to be very incomplete. Later this same incident was again referred to and elaborated.

He explained that until the birth of the other child he had been the apple of his mother's eye. Everything he did was wonderful and he luxuriated in his omnipotent position. With the arrival of his sister, when he was barely three years of age, the whole universe changed. He was completely displaced, and now, instead of being the spoilt and petted baby, he was expected to be the little man or rather the "governess", willingly and gratefully yielding everything in favour of the beloved new arrival.

The incident to which he referred was one which had brought his altered position home to him in a particularly traumatic manner. He said later:

"My scare was due to mother's anger which I could not understand. All I can remember is that I was absolutely aghast. *My wits left me.* I was knocked clean out. It was a sort of 'death' from which I have never recovered. I think from that incident I shut off my personality, or feelings, as independent of my mother's direction and influence. Mother picked me up by the scruff of the neck and shouted: 'You naughty boy. You dare to leave your sister to be ill-treated and selfishly amuse yourself with a little girl!'

"I was absolutely flabbergasted. I was so happy playing with the little girl. In fact I think I was so happy that that is why I did not notice my sister's screams. Then suddenly I saw my mother approaching like a hurricane, or like an avenging Nemesis. She would not speak until she got hold of me. I think as I saw her my mind went for any possible wrong I might have done and I did not find anything, and therefore I was quite unprepared for the onslaught. Since then I have never stuck up for myself. I have been completely submerged. Her anger was to me like the vengeance of God with a justness in it because it came from her and she could not be guilty of wrong. I was sort of hypnotised by the descending vengeance and I have been hypnotised ever since. I have never really thought I have had a leg to stand on. I could only conclude that anything I did on my own account, for pleasure, was utterly wrong. In fact the idea would terrify me. There was only one course for me to pursue from that moment, and that was to repress completely any inclination or feeling I had . . . any desires. And as repressing these *and* being aware of them is a painful experience, *it is better not to be aware of them at all.* That is why I feel nothing. I would not be allowed to express it or take pleasure in it if I did feel it, so it is better not even to feel it."

Later he says: "If I wanted to make mother take notice of me and made advances to her and clung around her skirt, she would always repulse me, tell me I was the elder child and I had to try to be a man, or else freeze me up, or blitz me. In some such way I learnt that my instincts were absolutely wrong, especially if I was inclined in any way to be cocky. But now I have seen quite clearly that I was wrong in denying my instincts and looking at them as the original sin that had to be trampled upon. That is why I have been trying to do things ever since *as though I had the instinct urge behind them.*"

At the next session the patient refused to lie down! Instead he insisted upon sitting up and facing me. It was a demonstration of the return of his "cockiness", this time directed against me in lieu of mother. He said: "What I want to talk about, what concerns me, is this difficulty in contacting women."

I said: "Instead of calling them 'women' shall we call them 'mother', it may make it clearer." But on this occasion he ignored my remark and went on to describe his "unwarranted" hesitations in speaking to young women whom he saw in public places and felt he should use for the purpose of exercising his utterly repressed self-assertion.

Very soon we arrived at a session which spelt crisis. There may have been an hysterical element in it, but my general impression was that it differed from the usual analytical crisis of the hysteric in that he had not even a dim consciousness of play-acting. He arrived late, stood at the front door and said it was no good his staying. He had merely come through his wretched "super-ego" telling him he might as well be polite to me and tell me in person that he was not coming. I told him of course that it was quite right to tell me all this, but it should be told while he lay on the settee. He stood with his hand on the handle of the front door and it took ten minutes to persuade him to enter the consulting-room. He proceeded to throw himself about on the analytical settee in great concern at the way he had typically and wretchedly messed-up an opportunity to let out his self-assertion in relation to a woman.

He said: "I was feeling a little self-assertion and then my blessed super-ego came along and said 'Your Jack has come too far out of the box. Now push it back again.'"

It was not easy to get him to tell the story consecutively, but he made some attempt.

"I felt panic all yesterday afternoon and I could not talk to the girl because I felt whatever I did would be wrong. I suppose it was because I felt a bit self-assertive."

ANALYST: "You have not told me the circumstances. You are keeping me in the dark."

PATIENT: "I got a bit of an erection."

ANALYST: "Well, what were the circumstances? Were you with the lady?"

He said: "No, we were not anywhere near each other, in fact she was in another town (!) It was not any question of being

together or anything like that; only she was with me in thought. It was that particular girl I told you about once before."

ANALYST: "*Well, seeing that she was not even there, how do we know it was her for whom you got these feelings?*"

He said: "Who was it then?"

ANALYST: "*I can tell you who it was.*"

PATIENT: "Who?"

ANALYST: "*Your mother.*"

PATIENT (ignoring my remark): "Then the panic came."

ANALYST: "*Naturally! If you get an erection for your mother, of course you panic.*"

PATIENT: "Then I had no feelings at all."

ANALYST: "*You were trying to stop the terrible consequences of the phantasy with your mother.*"

PATIENT: "I can quite agree with it. I have had little insights like that before, but to me it is only a label."

ANALYST: "*A label that reduces you to panic.*"

PATIENT: "My ego can only stand up and watch, so numbed that it cannot even *think* leave alone *feel*. I presume that that is associated with a memory of displaying affectionate emotion to my mother and being met by cold anger as used to be the case . . . as though she were acting for the Almighty, meting out punishment . . . it is more than anger . . . it is more righteous indignation . . . and there is some memory that sometime or other I must have run to her happy . . . I wanted to throw my arms round her . . . and I was met and flabbergasted by angry chastisement."

ANALYST: "*And it is still going on.*"

(A point of analytical interest is that this interpretation of "mother" for the girl has brought his mind to recount these remembrances of infancy.)

PATIENT: "The only thing my super-ego can do is to provoke me. Every time I let my Jack creep out of the box it is met by a fierce, angry storm. Do you wonder that I was flabbergasted, scared out of my wits? How did I know what was going to happen? I was full of affection and she simply turned on me."

"So I imagine any girl I meet is going to turn on me and rend me. She is going to catch me off my guard."

He then goes on to relate an incident earlier than the one at five. He says: "I wanted to restore the situation with my mother that had existed before the sister was born where I would be

the one she loved. I saw that baby that had taken my place, lying in a pram. Perhaps I was only three or four, but I saw my opportunity. I pushed that pram to where it would run away by itself down the hill. I just wanted her gone. I think it crashed at the bottom somewhere. I thought I could then rush to mother and be given my proper place. It was quite a time before I found her. I think now that she must have been picking up the baby and pram in the meantime. I ran to her glad and happy, but I think she must have seen it happen from a window, for I was simply met by a blizzard, and what can a child do under those circumstances! I was absolutely punctured and deflated. Mother made me good in the end, and now it is imperative that I should give an outlet to my self-assertion or be dead for the rest of my life."

Later he went back to the incident which had occasioned his initial despair on arrival at this session. He said: "I was not in contact with the girl at the time. It was just an upsurge of panic in consequence of my feeling a little self-assertive and having a bit of an erection. It keeps on happening continually. I am striving to feel self-assertion and when it comes I get in a panic and deflate the whole thing. What the hell is the good of me to any man or woman or beast or anything, if I am feeling so deflated!"

"Before my mother I was absolutely speechless. That connects up with my being tongue-tied when there is an emotional conflict in me. It is due to the fact that when I was fond of her she turned round and went for me and I was so surprised, I was so hurt at the unexpected and unfair treatment, that I just curled up inside. I can only feel the final feelings now and not the original ones."

ANALYST: "Still, that is some feeling after all."

PATIENT: "Yes, it may be feeling, but it is directed inwards instead of outwards."

Whether or not this patient's analytical material gives us some insight into the psychopathology of a very early schizophrenic process, it is certainly suggestive of the early infantile traumatic causes, operating upon a particularly sensitive disposition, which may induce repression of self-assertion, repression of all emotion and absence of affective response and a pretty thorough introversion. It transpired that his almost compulsive behaviour regarding attempts to pick-up strange women was really the

actualisation of an infantile compulsion to re-ingratiate himself with his mother, or failing that to show some self-assertion in pursuing his claims. He did not usually succeed in carrying it out in his experimental practice, as the attempt to do so would of course, and did, bring up the infantile conflict instigated by a fear of the "blizzard" or chastisement which such attempts would receive from the mother imago. He himself interpreted it as over-determined, in that it was both an attempt to win mother and to resume his enjoyable play with the little girl of his infancy.

The schizophrenic symptomatology in the form of acts or activities incongruous to his nature, age and status was suggested by the fact that before this interpretation had fully linked up in his mind, he would insist in regarding it as my duty, not to analyse him, but to teach him by encouragement or what-not to overcome his fear of speaking to these strange women and to give him courage to carry out his "self-assertive" acts in reality. This despite the fact that my reply was always to say the acts, ideas or phantasies had no relationship to reality, particularly the reality of the psychology of the women concerned, but were purely and simply nothing more or less than his tendency, through lack of insight, to play out in the present day his infantile struggle to regain his mother's attention. It appears that this was the only residue of "transference" left to support his emotional life.

The importance of transference interpretation as a therapeutic agent in all analyses, even those of narcissistic disorders, is partly revealed by the following excerpt from one of his earlier sessions.

He said: "If I do happen to remember anything of the past while I am in an emotionally repressed state it would be a purely *objective memory* . . . about a little boy whom I know was myself but *do not feel* was myself. Therefore as far as my feeling side is concerned it is quite *unreal*, and that is my present state. My feeling is unreal, is detached from me. The real 'I' is not there. When one says one is emotionally repressed one means the 'I' is emotionally repressed. If I reach an emotional state, it is only then that the 'I' can show itself, that is when the lid can be lifted from the Jack box. This treatment will only help me if you will be prepared not only to discuss some emotional problem that bothers me, but if you will be prepared to make

it real to me, because otherwise, unless you can succeed in making it real to me, I have the tendency to put it aside and look upon it objectively as unreal."

It is only when the patient shows affect towards the analyst within the analytical session that the immediate emotional situation is definitely real to him, and it is only by an interpretation of this immediate emotional *transference situation* that he is definitely prevented from objectivising his feeling and adopting this schizophrenic defensive measure of regarding it as a tale that is told about somebody else.

This patient, in spite of his schizophrenic mechanisms, increasingly brought his emotions into the analytical situation as was shown originally by his progressive inability to lie on the settee, and it was particularly the interpretation of transference that made him recognise beyond all shadow of doubt that he was still living his infantile conflict as though in its original setting with his mother. The unreality of his present-day emotional life and his introversion were the direct result of the primitive mental mechanism whereby the child had defended itself against feeling pain, namely, by dissociating all emotional feeling from consciousness. It seems to me that this is probably an important element in initiating the schizophrenic type of reaction—an initial movement which, with the appropriate pre-disposition, may conceivably progress to the extent of the mental disintegration more readily recognisable as schizophrenia.

The case of the sex-repressed and parent-fixated girl first described, together with this last case, may remind us that it is the Oedipus conflict which leads to such a strong and determined repression of sexuality, extending to all emotions, to the development of introversion in the form of unconscious sexual phantasy and to the consequent dissociation of libido from reality attachment.

Libido cannot reach reality if it is not permitted (on account of persistent Oedipus repression) even to reach consciousness.

Whether or not it subsequently regresses to the first oral stage of libidinal fixation these analytical excerpts do not reveal, but one may say that such a powerful Oedipus (or parental) fixation (particularly as that displayed by our first case with her total sex-repression) is indicative of an equally powerful precursor in the form of the first libidinal fixation to the parent—which of course is oral—in the pattern and intensity of which subse-

quent libidinal-object patterns must of necessity follow.

Hence we may regard the essential psychological factors initiating a pathological introversion and schizophrenia as those of parent-fixation with consequent repression of sexuality and subsequent regression of libido to early fixation points with a total deflection of it from present-day environment and an absorption of it in archaic unconscious phantasy.

CHAPTER XXI

PSYCHOPATHIC PERSONALITIES AND PARANOIA

A DOCTOR colleague came to me in great consternation. While he told me the story of his woes certain associations of thought formed in my mind which made me feel that the whole incident was worth recording.

His story was as follows. Some ten years ago his wife had become the victim of a serious mental illness. After a mass of symptoms which included the hearing of voices and other hallucinations, delusions of persecution and so on, she had finally become so violent that no other course had been practicable except to have her certified and removed to a mental hospital.

There, after some years of vicissitudes in health, she had finally settled down to a course of steady improvement. So much better had she now become that he had taken to having her home for an occasional day. As her behaviour was good, in the course of several months he extended this practice to having her home for a whole week-end, and finally for three or four days at a time. The results were everything that could be desired.

She harboured some resentment against those responsible for her certification and restraint, and a delusion that all this had been totally unnecessary if not positively criminal. But apart from this she was docile and well-behaved; so that finally, out of the kindness of his heart, he thought that the time was ripe to remove her from her irksome restrictions and let her try life in the normal capacity of housekeeper if not of wife.

He had launched upon this experiment some four months ago. The first month, though having some peculiar features, had not been too bad, but as time had gone on the position had become increasingly intolerable, though it was not easy to get an outsider to understand this intolerableness.

"What am I to do about this state of affairs, doctor? My practice and home are in the same house. The position would be humorous if it were not so tragic, and incompatible both

with my domestic comfort and with my ability to pursue my professional work.

"It is difficult to explain what I mean, but perhaps you will be able to understand. She is most punctilious and meticulous about the house. She counts every article of our possessions and draws attention to discrepancies which have arisen in the course of the last nine years. For instance, she knows exactly how many sheets we had nine years ago when she was removed, and wants to know which of my housekeepers in the interim has removed the missing half-dozen. Similarly with every article large or small.

"She practically runs my practice for me. She lets in every patient, knows all their names, addresses and so on, and often their private lives and business. She is insistent to know details of every complaint. She keeps a most rigid hand upon the financial matters. She demands that I should hand every penny of the money I receive over to her for her management and proportionment. She says I am extravagant and it is essential that she should keep a check upon everything.

"I think her idea is to allow me about one shilling a week for cigarettes and for my personal use. On the other hand, she is not at all economic about the household goods. For instance, she has made me waste several afternoons meeting her in various stores for the purpose of selecting flower vases for the various rooms, declaring she cannot tolerate those which I have acquired during her absence. Many of these are expensive articles which I cannot afford.

"At the same time she dictates letters, particularly to her past medical attendants in the mental hospital, long and sometimes vindictive letters, which she expects me to sign. Of course I do not post them.

"The essential difficulty of the situation is this: she is dictatorial and authoritative in everything. If I oppose her slightest demand or attempt in the most trivial degree to argue with her or to make her see reason, the result is disastrous. There is a flaming row; and if I do not give in, or appear to give in, I feel she would get seriously ill.

"The result is that I have to assess not only every action of mine but also every word I say with a view to its tolerability to her and its general effect upon her. My sleep is suffering; in consequence my practice is going to pieces; I feel I cannot do

my professional work under the strain of this psychological situation.

"She appears to have identified herself with me, or rather me with herself. To her mind we are one. She thinks I share all her delusions regarding her previous medical attendants. She talks about 'us' and 'we' always, while at the same time she views the rest of the world, including the patients, with a marked degree of suspicion. There seems to be nothing I can do about it."

"The psychology of the position seems to be that her mind is impervious to any external influence, impervious to the realities around her, including economic realities, and totally impervious to my opinions, wishes or reasoning. As a result I feel that I am in a prison both real and psychological and I can see no way out."

"It would be no good getting a legal separation because not only would she refuse to sign it, but she would be equally impervious to any legal ruling. She would appear in my home just the same and proceed to manage me. I feel I am completely trapped and chained hand and foot."

While I was listening to this doctor my mind was at the same time reflecting upon such questions as the popular conception of "strength of character", the unalterability of certain persons' minds, and their total imperviousness to external influences including reality and reason. I thought of minor instances of similar difficulties concerning husbands and wives who had previously consulted me regarding their marital partners.

But in particular I thought of certain dominant political figures, and of one who seemed to fit this dictatorial psychology most markedly. It occurred to me that the only essential difference between the psychology of this woman and that of Adolf Hitler was that his domestic domain had extended to embrace the whole of the Third Reich. He had identified himself not with a marital partner but with the nation with which he had united himself. They were one; the rest of the world was to be looked upon with suspicion, or more than suspicion; a definite conviction of encirclement and malevolence.

In particular he and this housewife were identical in their imperviousness to all external influences which impinged upon their rigid mental system. Hence the apparent strength of character. Intolerance, unmodifiability were the keynote of this. Nothing was permitted in any circumstances to modify the rigid delusional system which had at all costs to be exactingly put into

operation and acted out in every particular.

Psychologically the essence of the situation is unalterability in one's thoughts, immunity from all the impingements of the environment, and, in consequence, being oneself unalterable, a necessity to alter the environment to fit one's own psychology, with an insistence which suggests that the operation is essential for the maintenance of one's own health or one's own life itself.

The fixed determination with which the paranoiac clings to his delusions and his complete imperviousness to the evidences of reality, reasoning, arguments, etc., are due to the fact that these delusions are not primarily founded upon any reality evidences or objective experience.

On the contrary, these delusions are the result of disordered subjective experiences (compare Hitler's intuition). Through some frustrations, inhibitions or perversions of his instinctual or feeling nature it is unavoidable that he *feels* something of a *mental* nature.

Reality is only useful in so far as it can provide, even by distortion, some (to him) confirmation or reinforcement of the feelings which he must have at any cost. He will distort the realities to suit these feelings and will most certainly ignore any realities or arguments which threaten to deprive him of instinct-engendered feeling of which his delusional life is the only expression possible to him.

In the deeper analysis of such cases I have come to the conclusion that their delusional system has to a greater or lesser extent taken the place of their main biological urges, or indeed of their whole sexual life. No power in heaven or earth can take this away from them.

High-grade paranoiacs are notoriously convincing. Many of us can remember the famous case of the litigating paranoiac who convinced a judge and jury that his entire delusional system was the truth, and obtained judgment against his alleged persecutors. It took endless legal trouble to disprove the matter on appeal.

I myself have listened for an hour or more to a paranoiac's convincing story of the plot which resulted in him, "a sane man", being incarcerated in the mental hospital where I was interviewing him. The story was perfect. It would have convinced any jury and, so far as it had gone up to that point, I could find no grounds to question it.

However, being encouraged by my apparent credulity, he extended it to the doubtful thesis that the daughter and son who visited him there were not his real daughter and son for they had been murdered by the conspirators. This son and daughter were impersonations, remarkably clever, even identical in voice, but he with his special intelligence could see through the make-believe.

Finally he asked me to promise that I would identify him every day on my rounds, for he was convinced that the time would come when it would be his turn, as he had witnessed in the case of so many of his co-inmates, to be spirited away to the local incinerator (actually the hospital's laundry chimney!) never to be heard of again.

So much for the main outline of the psychopathology of paranoia in general. The particular *form* which the system of delusions takes in specific cases is determined by a number of less fundamental causes and mechanisms.

I have gone into these in some detail in my book *War in the Mind*, where I have indicated that in the case of Adolf Hitler there was also a considerable hysterical mechanism at work. This seems to have been founded upon a strong attachment to his mother, and a correspondingly strong, though evidently repressed (*i.e.* largely unconscious), hatred of his father.

In the face of continued and perpetual frustration from early childhood of strong aggressive urges connected with father hatred, he felt that there was no course, other than that of enduring internal agonies, than to vent his hatred, not specifically upon the father for that person as the object of his hate had been repressed from consciousness, but upon all and sundry. The bigger the explosion the greater the relief.

Are all the would-be conquerors of the world, the historical aggressors, like Hitler, like some of the patients with whom I have to deal, unconsciously trying by their aggression—outward or inward in the form of fits and symptoms—to rid themselves of intra-psychic tensions which have become intolerable?

If Hitler had been psycho-analysed it would, I think, have been found that the circumstance which roused him to the greatest frenzy was one in which he conceived of the mother, or of her symbolical equivalent such as the "pure" woman, as having been ill-treated or attacked by a father-equivalent.

The pure woman we can detect in *Mein Kampf* by the equiva-

lent symbol of the blonde Aryan German girl; the father-equivalent by such symbols as the Jews.

All humanity was apparently divided in his mind into two contrasting opposites. There was a very sharp line between them. On one side of the line were innocent or good people, such as himself, his fellow Nazis and, by extension, the Aryan German race. On the other side of the line, contrasting with the former as black contrasts with white, were the bad people or "devils". They included all persons and races not identified with himself.

His psychology was so built up that he had to spend all his life protecting the mother-equivalent (with which he identified himself) on the one side, from the diabolical father-equivalent on the other. Towards the former he had to be nothing but tenderness, so much so that he suffered from grave inhibition in his sexual life. Towards the latter, and towards them only, he was psychologically free to vent the great mass of hatred and aggression bottled up within him. Compare the psychopathology of the "epileptic" described in Chapter XVI.

It is the equivalent of letting loose the frustrated revenge against the bad father who in his phantasy so diabolically ill-treated the good mother.

Of special interest in international politics is the psychological reflection that in the unconscious mind one's *motherland*, or *the place of one's birth*, is symbolically the equivalent of the good mother. Of course, it makes little difference if it is designated as one's fatherland; it is still a mother-equivalent.

It will thus be seen that for a person with this type of psychology any injury to his mother country will be resented as the most heinous outrage. Those who perpetrated such an act would be unconsciously identified with the diabolical father and no degree of revenge or punishment would be too severe for them. For instance, those who to his mind "mutilated" the German Empire at the Treaty of Versailles would certainly belong to this category.

The fact that it may be possible to justify (or appear to justify) such behaviour on reality grounds is no refutation of its real source from *unconscious* psychological forces. Every medical psychologist knows that the intellectual (or reasoning) faculty is often merely the servant of the deeper (unconscious) levels of the mind and is rarely at a loss to find "reasons" or rationalisations for carrying out and justifying the latter's behests.

Thus some patients can find "reasons" for all sorts of irrational vindictive acts and Hitler found "justifications" for one nation or race attacking other nations and races. The avenger, or punisher, has in his unconscious those very tendencies the expression of which he is so ready to avenge or punish—and in a strength proportionate to the strength of his revenge tendency.

Occasionally they reveal themselves. Thus we see him who is filled with indignation and revenge at the rape of his mother country himself devoting his life and all his energies to the systematic rape of his neighbours' mother countries. "Justice", or at least punishment, was always another way of performing the very same crime that we profess to avenge or destroy.

Thus we saw that with Adolf Hitler, while the main outline of his psychopathology was that of the paranoiac, there were, as is always the case in any major illness, many subsidiary psychopathological trends and patterns undoubtedly including that of major hysteria.

Such blatant forms of paranoia as that of the asylum case mentioned in this chapter who believed that the son and daughter who visited him were impersonations are, of course, easily recognisable. That of the doctor's wife described at greater length might (in the absence of her asylum history) escape suspicion, and in her present condition has to be carefully studied to be detected.

But it is the even less obvious forms, albeit with similar characteristics (for instance the rigid unalterability), which, through their apparent strength of character, so frequently gain allegiance from less rigid or strong-minded persons in their vicinity, and commonly become leaders of groups, sects, cults and even of nations.

Their recognition is a prerequisite for the avoidance of future wars and for the safety of mankind. In general they are of all persons the least amenable to analysis.

Perhaps we cannot better conclude this chapter on graver illnesses than with an extract from Freud's writings showing that attempts to draw a sharp line between "nervous" and mental illness are doomed to failure, and that varying degrees of ego impairment are inseparable from every mental disturbance, forming a graduation from minor ills to psychogenic psychoses proper. Freud said:

"Not long ago in quite a speculative way I formulated the proposition that the essential difference between neurosis and psychosis consists in this: that in neurosis the ego suppresses part of the id in favour of reality, whereas in psychosis it lets itself be carried away by the id and detached from a part of reality. But soon after this I had cause to regret that I had been so daring. In the analyses of two young men I learnt that each of them—one in his second and the other in his tenth year—had refused to acknowledge the death of his father—had 'skotomised' it—and yet neither of them had developed a psychosis. A very important piece of reality had thus been *denied* by the ego, in the same way as the fetishist denies the unwelcome fact of the woman's castrated condition. I also began to suspect that similar occurrences are by no means rare in childhood, and thought I had made a mistake in my differentiation between neurosis and psychosis. It is true, there was one way out of the difficulty; it might be that my formula held good only when a higher degree of differentiation existed in the mental apparatus; it might be possible for a child to deal with what would cause severe injury in an adult. But further research led to another solution of the contradiction.

"It turned out, that is, as follows: the two young men had no more 'skotomised' the death of their fathers than a fetishist skotomises the castration of women. It was only one channel of their mental processes that had not acknowledged the father's death; there was another which was fully aware of the fact; the one which was consistent with reality stood alongside the one which accorded with a wish. One of these two cases of mine had derived an obsessional neurosis of some severity from this dissociation; in every situation in life he oscillated between two assumptions—on the one his father was still alive and hindered him from action, on the other his father was dead and he had the right to regard himself as the successor. In a psychosis the true idea which accorded with reality would have been really absent."¹

It would appear from this pronouncement by Freud that the essential difference between a neurosis and a psychosis is that in the former *some part* of the mind retains a true appreciation of reality in regard to the particular emotionally charged matter,

¹ Sigmund Freud, *International Journal of Psycho-Analysis*, vol. 9, pp. 164-5, "Fetishism."

whereas in a psychosis all reality sense regarding this matter is absent. The corollary is that even in a neurosis *some part* of the mind has lost its reality sense. In other words, the difference between a neurosis and a psychosis is that in the former, with reference to some particular matter a part but not the whole of the mind is "mad" and that neuroses are *partial* or incomplete psychoses. It only remains to add to this that there is no such thing as a mind which is 100 per cent. appreciative of reality, without some skotomisation, or in other words, the normal mind also has its elements, however relatively minute and incomplete, of psychosis. It will thus be seen how impossible it is to draw a really sharp line of demarcation between any of the three mental categories, normality, neurosis and psychosis, unless we regard them as abstractions having no other clinical reality, as every case we investigate will exhibit all their characteristics in varying proportions.

CHAPTER XXII

PSYCHOPATHOLOGY OF SCHIZOPHRENIA AND OTHER DISORDERS

In the following pages I hope to show that all psychogenic illnesses have their inception in one identical, initial mental movement. This movement is in essence a retreat from unsuccessful instinct-reality adaptation into introverted sexual phantasy. The various psychogenic neuroses and psychoses represent different stages and different degrees of severity of morbid processes consequent upon this initial movement.

Practically all psychiatrists are agreed that schizophrenia and paranoia, despite the apparent divergence on superficial observation of their symptomatology, nevertheless belong to the same group, and that it is probable that they are manifestations of the same morbid process.

There can be no question of their outstanding importance in the study of mental disorder if only from the fact that about 16 per cent. of admissions to mental hospitals are cases of schizophrenia, and *more than half* of the permanent mental hospital population are suffering from this illness. Perhaps it is for this reason that psychiatrists have given it more attention than any other mental disorder both as regards its physical investigation and its mental manifestations.

It has been most carefully examined on the physical side from microscopic investigation of brain cells, gonads and other endocrines, septic foci, etc., to physiological processes including basal metabolic rate, oxidation processes, such as the function of oxidase granules in the body of brain cells and dendrites, protein metabolism as manifested by disturbances of nitrogen excretion, blood-sugar liability, etc. etc.

Mott believed that a defect in the "vital energy" of the fertilised ovum was the main cause. This resulted in progressive failure in nuclear proliferation and arrest of spermatogenesis in the *testes*, and similarly in signs of early involution in the *ovaries*.

He elaborated a neurological theory which was briefly as

follows. He thought that the intercalary neurones of the *cerebral cortex* with their large nuclei were concerned in the transformation of the molecular oxygen of the oxidase granules, found in the body of the cell and dendrites, into nascent or atomic oxygen which is necessary for all neural activity. Iron or phosphorus present in the nucleus acts as a catalyst. Mott thought that the atomic oxygen so formed causes amoeboid movements that bring the cell processes into contact, or the atomic oxygen causes combustion of sugar with resulting energy discharge which stimulates adjacent neurones. These normal processes, Mott found histological evidences to indicate, were defective in the cases of schizophrenia which he examined after death. In general his histological examinations suggested to him defective oxidation and hypo-function.

Many other observers have claimed to have found various physical and physiological changes worthy of consideration as causative factors, but whenever some investigator has claimed to have made outstanding discoveries of a specific nature these discoveries seem to have been brought to naught by some other equally or more competent investigator. Mott's work which claimed so much attention at the time was subsequently criticised by Morse, who instead of being content with the histological examination of advanced and debilitated cases, many of whom may have died from inanition and intercurrent disease, investigated established cases of schizophrenia *in which death occurred from misadventure*. Morse showed that no such cases exhibited the histological findings discovered by Mott, and that for instance the arrest of spermatogenesis which he suggested was pathognomonic of schizophrenia was really produced by inanition, as it is in any person dying from this cause.

In short, the general result of investigations along physical lines can be summed up in the words of Dunlap, with whom R. D. Gillespie was in agreement: "Schizophrenia is a condition lacking in any fundamental or constant alteration of nerve cells, and any nerve-cell alterations that are found in schizophrenia are probably a reaction to various, mostly unknown, bodily conditions, plus post-mortem and technical factors". It would seem therefore that, in the present state of our knowledge, in the absence, despite every effort, of any reliable explanation on a physical or physiological basis, we are forced to fall back upon a possible psychological aetiology.

If we turn to the psychiatrists who see the vast majority of established cases of schizophrenia, we find descriptions of its psychopathology, based as they are upon purely superficial and conscious-level observations, most unsatisfactory to the analyst. They offer explanations which are hardly explanations at all as they leave untouched the initial causes, beginnings and mechanisms. For instance, Kraepelin describes it as an "impoverishment and devastation of the whole psychic life, which is accomplished quite imperceptibly". Can analytical investigation succeed in perceiving what Kraepelin found "imperceptible"? In fairness to Kraepelin it should be said that he considered the real cause of the illness to be auto-intoxication produced by disordered secretions of the sex glands, an opinion which led to Mott's researches.

In the forefront of the *psychological* aetiologies, we have already mentioned (Chapter XX) Meyer's view that schizophrenia is the result of a progressive maladaptation of the individual to the environment. As Gillespie in his exposition of it says: "The healthy attitude to life's difficulties and problems is a direct, aggressive, matter-of-fact one designed to overcome the difficulty once and for all, with the result that the individual feels satisfied and can proceed confidently to his next problem". A tendency to compensate for failure by retreat into day-dreaming—I would add: with a certainty of an activation of conscious or unconscious sexual phantasy—may be the initial element in the process of withdrawal from healthy reaction towards reality and in a dissociation of the conative, affective and all other elements in the mental life from any relationship to environment or to reality. Subsequently, the saga of introverted and unconscious happenings and gratifications, having developed without reality contacts and without reality frustrations, may, when the presence of any reality has been successfully ignored or forgotten, show itself in various forms as though there were no such thing as reality to be taken into consideration. Thus we may get inappropriate actions as well as inappropriate thoughts and feelings—inappropriate to reality. Examples of such processes are revealed in the cases quoted in Chapter XX. Frustrations, if not completely avoided, are then "dealt with" by an immediate dissociation from reality and further introversion.

With regard to this group of disorders some psychiatrists, particularly in reference to paranoia, have gone so far as to dis-

cuss whether the primary disorder was one of the intellectual faculties or the affective disposition, in spite of the fact that even superficial analytical investigation, including that of intellectually disordered cases of paranoia, reveals that even the most elaborate delusional system derives the whole of its dynamic energy from affective sources, and, as I have mentioned in the chapter on "Psychopathic Personalities and Paranoia", there appears to be a necessity to maintain the delusion with an insistence which suggests that it is essential for the maintenance of the sufferer's health or for the maintenance of his very life. Indeed, he has little or no other emotional outlet, and it is pretty clear that his illness has largely taken the place of his sexual life.

In spite of Freud's view, for which there is much evidence, that paranoia is a projection of repressed libido that had previously been fixated at a homosexual level of development, I think that some cases show that this projected libido need not necessarily have been homosexual, but may have been heterosexual, though at an Oedipus or earlier level. Admittedly, it is homosexual fixation which would tend to meet with greater difficulty in objective, reality expression. At the same time, Freud believes that in cases of schizophrenia the libido is fixated at an earlier level than the homosexual, in fact, right down to the first oral stage, and that the symptoms of this graver form of the disease are attempts at id-gratification or self-cure.

Other psychological views, though relatively more superficial, all appear to have considerable justification in the light of the analysis of any of these introverted cases, depending rather upon the particular level which the analysis has reached. For instance, McDougall's concept that the two components of his so-called "sentiment of self-regard", namely the self-assertive and self-submissive elements, do not function smoothly, but enter into a conflict which leads to a rigid embarrassment resulting in no effective action or self-expression, is clearly shown in the patient whom I quoted at some length in Chapter XX. In close accord with McDougall's theory this patient never freely asserts himself and never wholly submits.

Jung's concept of the schizophrenic as thinking, acting and feeling as one in a dream, is undoubtedly in accordance with clinical observations and the fact of his dissociation from environmental reality. It is pointed out that the child's normal

reaction to an intolerable world is naturally a flight into phantasy, where, separated from the frustrations of reality, all wishes may be gratified. That is perhaps why it is more usual for the disorder to begin in early life, commonly between fifteen and thirty years of age, when the conflict between the increased power of instinct urges and the frustrating environment becomes most intense. Compensatory phantasy initiates a retrogressive activity of the libido, reactivates unconscious patterns and emotions, and the energy of life is to that extent confined to the unconscious and withdrawn from reality adaptations. Such a process is the antithesis of progress, development and evolution. Therefore one would expect, as Jung says, a tendency to "regression to elements in the collective unconscious", or an undoing of evolutions and adaptations, and a reactivation of archaic mental processes, the movement finally leading to that total dissociation from reality which may be the beginning of the grave changes which it is so difficult to account for on the hypothesis of a psychological aetiology.

Regarding this difficulty, Stern¹ points out that we have only to suppose this dissociation from reality extending to deeper levels in the central nervous system and we might expect a process similar to that following a section of a part of the brain stem. Typically, he says, "We should expect decerebrate rigidity in which the subject stands still, indifferent to stimuli" and in which the results are hypertonic, in short, the typical condition of catatonic rigidity. Pavlov produced a similar condition in the dog during a stage of incomplete sleep. He attributed this condition to inhibition of the cortex where the senses regulating equilibrium were left to work retrogressively and independently. As Stern says, the condition bears an obvious resemblance to decerebrate rigidity. This view makes the effect of electric shock therapy more understandable, as the central nervous system, being an electrical organ, we should expect that this dissociation could be ended by a sufficiently strong stimulus breaking through the dissociating barrier. Stern considers that in cases of paranoid type the dissociation is at a higher level in the central nervous system, affecting only mental processes and therefore not leading to catatonic rigidity, whereas in dementia praecox the dissociation is so complete that consciousness is largely inhibited, and there is as a result some degree of hypna-

¹ Stern, *British Journal of Medical Psychology*, vol. 19, part 1, p. 119.

gogic state. I think one might add that a slighter degree of some such state exists in severe cases of hysteria also, and, though it does not lead to catatonic rigidity, it may help to explain some of the paralytic and spastic phenomena, although the organisation of these may be of a higher order than that of the dissociated elements in schizophrenia.

Many of the symptoms of the dementia praecox are defensive ones. If he lives in a dissociated pleasure world he must avoid the intrusions that would wake him from his dream; hence his hebephrenia, or stupor,—hence his negativism, or mutism. They are the natural reactions of the "sleeper" protecting himself from being awakened. His bursts of catatonic violence may on occasions be instances where defence has turned to counter-attack. As Stern points out, automatic obedience, echolalia and echopraxia, may be attempts to avoid interruption by the alternative process of offering no resistance. On the other hand, a good deal of catatonic excitement is doubtless the acting-out of phantasy with total disregard of all surrounding realities. He holds the view that patients suffering from dementia praecox need plenty of stimulation and if left to themselves tend to become more demented, that is why they do badly in institutions where the policy, apart from shock or insulin therapies, is to avoid trouble, if possible by "letting sleeping dogs lie", for the completely introverted hebephrenic or stuporous patient makes for peace and quiet in all around!

Gillespie implicitly indicates a similar view regarding the psychological treatment of early schizophrenics. He deplores the fact that they are commonly not brought to the psychiatrist until the disorder is thoroughly established, and suggests that the bizarre conduct, tantrums and difficulties of child life should be scrutinised much more closely as a prophylactic measure and that tendencies to retreat into day-dreaming and so on should be met by encouraging external interests, particularly in those predisposed to morbid introversion. He advocates that shy, nervous and sensitive individuals should be encouraged to talk over their difficulties more freely so that they will not be tempted to seek introverted retreat. He believes that the showing of an individual interest (and, I would add, understanding) in cases of this kind is of paramount importance in preventing the disease and in helping the patients in the earlier stages, and goes so far as to suggest that a lot of the benefit derived from special

methods of physical treatment, such as insulin, etc., may really be due to a psychotherapeutic process brought about by the physician's increased interest and attention. In my experience there is little doubt that the same applies, perhaps even to a greater extent, in very early cases with paranoid tendencies and ideas of reference. If properly handled they are capable of as strong a transference to the psychotherapist as any case of hysteria, though admittedly there is the possibility of the analyst being identified with the "bad image" in the end.

Discussion: Psychologically there are two ways of achieving id-gratification. The first is by manipulating reality so as to achieve the gratification, direct, substituted or sublimated, in the real world. This is the normal or healthy process. The second way, which certain types of mind are more prone to adopt than others, comes about when the fight against frustrating forces in the reality world is abandoned. Id-gratification is then relegated to a world of unconscious phantasy and facilitated by the exclusion of interrupting reality. This is a process which, if it takes place to a large extent before the mind is adequately hardened by maturity, may initiate an introverted libidinal flow which may continue to retrogress until it produces all the phenomena of schizophrenia. Thus we see that if no physical aetiology is established we are forced to adopt this psychological theory to account for a process which can progress to dissolution of mind and body.

The grave symptoms of the advanced catatonic or dement give the impression that they must emanate from physical or at least physiological disorder. If this is so, if the *later* symptoms spring from organic sources, what are we to say about the earlier or the earliest (mental) symptoms? Would it not be only logical to assume that they also must have been, in the light of further developments, due to organic causes, presumably the first and at that time the only manifestations of these incipient organic changes? Or are we to postulate that though the later, grave symptoms of this psychosis must have organic causes (physical or physiological), the early (mental) symptoms, on the contrary, are adequately accounted for on a psychogenic aetiology? In this case we would have to say that schizophrenia is a disease which is initiated by psychological causes (such as conflict), and that, as a result of this mental process, certain physical or physiological processes take place in the body and brain which

in turn produce the grave symptoms, including dementia, of the advanced stages of the disease.

This may be the truth, but one can well understand dissatisfaction with such a hypothesis, and a leaning towards the view, in spite of absence of evidence in the present state of our knowledge, that some primary, as yet undetected, organic factor is responsible for *all the symptoms* including the early mental ones as well as the later dementia and bodily deterioration. But even if, despite the absence of evidence, we lean to this view, that the primary cause of the condition is organic, we still have to account for the coming about of such an organic cause. In other words, the establishment of physical causes would not really solve our problem.

To my mind the best possible hypothesis, in the present state of our knowledge, is in accordance with my general theory that, however much physical and chemical factors were responsible for the phenomena of life in its earliest and most primitive stages, once a nervous system is established, it, or the subsequent mind, becomes the spearhead of adaptation to environment and the important agent for evolutionary change in the process of biogenic (and I would add Lamarckian) evolution.

I consider that a study of the state of schizophrenia, including the revelations of physical and mental investigations, should incline us to the view that the mind and body are inseparable, and that the changes in schizophrenia are manifestations of a single morbid process initiated by a morbid form of id-gratification, through phantasy instead of through reality adaptation, and extending through the generations (Lamarckian-wise), affecting both mind and body as one integral whole.

Let us return for a moment to clinical material for a further assessment of these hypotheses.

If one spends one's time listening to every variety of psychogenically disordered patient expressing his complaints and his free associations of thought, the earliest beginnings of a schizophrenic mental process are frequently, if not continuously, revealed in various degrees of intensity.

For instance, an extraordinarily slow-moving and slow-thinking single man of thirty-five, highly educated and thoughtful, but with the facies of a boy of nineteen, puts in the forefront of his symptom-picture a continuous and lifelong state of what he calls "mental tiredness". He denies depression and explains:

"My brain always keeps on going to sleep for little intervals and I cannot control it. Even while people are talking to me I find my mind keeps lapsing and coming back." He declares that the process began as far back as he can remember, as early as the age of six or eight, and that it has continued ever since. It may have got a little worse at puberty. Later it transpires that he connects these repetitive lapses of mind and his perpetual mental tiredness with a habit of indulging in sexual phantasy. He says: "From at least the age of six or eight I was subject to sexual desire. I did not indulge in ordinary masturbation, nor have I done this or any other sexual activity, but I have indulged in the habit of abusing myself mentally. There is no doubt about it being sexual for it is always accompanied by a state of erection more or less, an erection which comes and goes in lesser or greater degrees and is brought about simply by a process of thought. This I am sure is responsible for my constant lapses of thought and for my perpetual mental tiredness."

There are attempts at least at reality contact in his more or less unconscious sexual phantasies, for the event which has brought him to treatment is a recent attachment to a woman friend in spite of the fact that he had always assumed that he was, as the result of this sexual-phantasy practice, "permanently unfit for marriage". Although his sexual impulse was generally confined to phantasy never having found expression either in sexual intercourse or in masturbation, on a certain occasion with this woman friend his phantasy led him to a tentative approach to her with his hand, and this much reality contact he was finding stimulating to his eroticism, though, as he says, it never has or would lead to a natural handling of the female genital. However, so far all was going well in phantasy, despite the lady's persistent frustration of reality progress. Further evidence shows that this success was largely *due to* the frustration on a reality plane, for presently when she explained her resistance by telling him that she felt his advances too strongly and in fact was in love with him, instead of experiencing the usual positive response he tells me, "I was immediately paralysed with fear—fear so strong that it was practically *nausea*. All sexual feeling immediately vanished with this fear."

Now this patient had a dream in which he was in a dark hall with a dangerous male enemy who disappeared through a door. A woman (identified as partly his woman friend and *partly his*

mother) was beside this door and she kept opening and shutting it at irregular intervals. The room on the other side of the door was brightly lit. Every time she opened the door the dreamer had to take immediate defensive action (for instance by throwing something to ensure the door being closed at once) otherwise he says he would have been "finished".

This is an acute anxiety dream symbolising his fear of the woman opening her door (*vagina*) to him. He identifies it with the acute fear he felt when his woman friend declared she loved him. Its identity with the Oedipus situation is evident. Thus we see that the intensity of this Oedipus anxiety is the essential intra-psychic factor responsible for his fear of objectivising his sexuality, and his Oedipus frustration is the essential ingredient of his erotic phantasy life and responsible for a withdrawal of this part of his mind from reality contact.

We can see too that this introverted libido tends all the time to attract his attention towards itself and to withdraw it from current realities such as a conversation he may be having. This is the first symptom he mentioned in connection with his mental tiredness. We can well imagine that if the withdrawals from reality were more prolonged this patient would be indistinguishable from a schizophrenic. As it is there is little affective life left in the "dark hall" of his conscious mind and he is terrified of the emotional intensity of his unconscious levels. If, on the other hand, the withdrawals from reality were only an occasional and less marked feature of his psychology, indicating a less severe Oedipus fixation and in consequence a less intense castration anxiety, the energy of his sexual instinct would be finding expression in normal heterosexual contact and expending itself in detumescence, and leaving the rest of his psyche free to utilise the residue of energy in further reality contacts. In short, he would be normal. Are we therefore here investigating the essential element in the initiation of the psychology of schizophrenia?

A tall, thin girl of twenty-two exhibiting many of the physical stigmata of schizophrenia tells me that the depressions of which she complains start with sexual feelings are related to her menstrual cycle and began at fourteen, about three months before her periods started. During analysis she expresses the opinion that if she were leading a normal sex life, particularly if she could get sexual satisfaction "*in time*", that is to say at the

moment when she is feeling sexual, then, she says, the depression would not come on, and what is more she would never get depressed again!

Although her history shows an extreme paucity of heterosexual contacts, it shows enough to demonstrate that, unfortunately for her theory, the sexual feelings never do come on when she is with a would-be man friend; and, indeed, when such a one has pressed his sexuality upon her she has invariably been entirely incapable of the slightest feeling-response. In short, her sexuality only flourishes in the *absence* of any reality contact and therefore, despite her theory, is a thing apart from current realities, being confined to introverted phantasy.

Why is it that some males persist in thrusting themselves upon such introverted women to find, as they invariably do find, that they have married a permanently more or less frigid wife? Is all frigidity and impotence a manifestation, at least in part, of such schizophrenic mechanisms? I believe it is.

This particular patient described her mental content as follows: "It is like being in a dream, though mostly I don't know what the dream is about. At times it is accompanied by sexual feeling, and then I get this depression because there is no means of satisfying the feeling. At the same time on account of this dream I don't know all the time what I am saying and what I am doing. I go about in a sort of daze, feeling as though I were perpetually drunk. If people noticed it they would think I was absolutely mad."

In spite of these exceptionally revealing remarks, this patient proved almost as unapproachable mentally as she evidently was unapproachable physically. Her heart was apparently as cold as her hands. At times one even got the impression that if a pin had been stuck into her she would not have felt it. Very little mental-emotional contact could be established, but she showed surprisingly rapid improvement when subjected to electric convulsive therapy, the depression, which was a recurrence only six weeks old (after two years of relative health and a previous attack of four years' duration), vanishing immediately after the first electrical treatment. Unfortunately this excellent result was not maintained.

A more markedly schizophrenic young man of twenty-three suffering from mental fatigue and with a tendency to dreamy states, ideas of reference, and some evidence of auditory hal-

lucinations, whose father says he has never shown the slightest interest in the opposite sex, tells me that he met a girl whom he "would not mind marrying", but he has "never bothered to meet her again". And it transpires that he does not even remember her name. He says: "It seems queer!" The "queerness" is due to the fact that he prefers his romantic-neurotic phantasy life to any reality contact. His libido has withdrawn itself from reality and become introverted, preparatory to further regressions, unless reality contact can be re-established.

In the meantime he is not only indulging in the usual adolescent day-dreams of romance and achievement, but is substituting these for all reality manipulations and endeavours. His megalomanic tendencies, such as ideas that he can accomplish anything from scholarship to genius in spite of reality evidence to the contrary and in spite of the absence of any attempt at accomplishment, obviously emanate from phantasy. If we ask the nature of this phantasy and the mechanism of the production of megalomanic ideas, analysis reveals the following answer: *The buoyancy of erotic feelings and fantasies, unimpeded by any reality contacts, creates a sense of omnipotence sometimes revealed in the familiar erotic dreams of floating on air, flying effortlessly, etc., and similarly in schizoid states equivalent delusions of one's effortless omnipotence.* The source and mechanism is the energy of the sexual instinct creating tumescence without conscious effort, or even without conscious co-operation or knowledge. This is another instance of the fruits of the schizophrenic dissociation from frustrating and inhibiting reality. The point I wish to emphasise is the source of the symptoms in dissociated sexual phantasy.

My theory of schizophrenia, based upon this clinical material and upon that described in the preceding chapters, particularly in Chapter XX, and taking into consideration other psychological theories and the absence of evidence of organic primary causes, may be enunciated as follows:

The schizophrenic process begins in the manner with which we are familiar in all psychogenic disorders, namely, with a repression of Oedipus sexuality—repression meaning a certain degree of dissociation or splitting. The process therefore begins very early in life and probably no person is free from some modicum of it. The repressed libido gives rise to more or less unconscious sexual phantasy, and through its withdrawal from

reality is responsible for that degree of introversion. If the quantity of repressed libido is sufficiently great, and if sexual frustrations and inhibitions prove stronger than the tendency to extroversion of the developing libidinal drive, this developing libidinal energy will also tend to become repressed, and will therefore introvert and reinforce the dissociated or split-off Oedipus nucleus. That is why schizophrenic tendency is fostered by pubertal and post-pubertal frustrations and inhibitions, the introversion increasing instead of decreasing.

But here an overwhelmingly important physical element comes into the morbid picture and contributes on the material or physical side what mere psychological processes or libidinal flows could no more cause than could a thought process, without the executive mechanisms of the voluntary musculature, produce changes in the material world. This overwhelmingly important physical element is the organic changes developing in the body in general and in the gonads and other glands in particular, coincident with the onset of puberty. These developmental changes should normally initiate a new or altered relationship to environmental reality, specifically a new form of behaviour towards the complementary sex, as witnessed in the animal world during the breeding season. But, owing to their psychic mechanisms having become introverted, and such reality adjustment being in consequence impossible, the physical and chemical forces developing at puberty do not obtain this normal outlet, and accumulate instead within the organism to produce physical, organic and nervous tensions, as capable of producing changes as momentous and as destructive to the individual holding them in, as their normal expression would be capable of momentous biological changes in the form of multiplication of the species. If these forces can produce innumerable members of a species ("massive production without limit") when they go into outward expression, surely it should not surprise us if they can also produce the destruction of an individual when they remain bottled up within him. Therefore nothing, from schizophrenia to cancer, or death itself, should surprise us as a consequence of this originally insignificant, initial mental movement towards psychosexual introversion.

Once a preference is established—a preference based upon the pleasure-pain principle and the avoidance of fear—for introversion, for indulgence in phantasy and against the now dis-

turbing reality connections, the morbid process is in operation, the libido is turned from reality contacts and into a world of pleasure-giving phantasy, largely unconscious phantasy. This is the initial movement in schizophrenia.

In certain cases so large a proportion of libido is drawn towards the repressed or split-off part of the personality that contact with reality is sufficiently lost for schizophrenia to be diagnosable.

Whenever outwardly-directed libido, having met with frustrations which it cannot overcome, gives up the struggle and retreats instead to introversion, the stage is set for a mechanism with which we are familiar in all psychogenic disorders. This mechanism is that of regression. The repressed libido regresses, activating in turn not only the Oedipus complex but earlier and earlier pre-genital libidinal organisations, retreating further and further from any possibility of reality contact until the earliest organisations of the libido are activated and absorb practically the whole of the libidinal energy. Finally, the regression is to unorganised libidinal fixations such as bodily enervations, vaso-motor system, etc., resulting in such physical manifestations of the disease as catatonic postures and bluc extremities. The endocrine changes, which have been so much stressed by the exponents of the organic theory of causation, should present us with no difficulty for it is well recognised that the first physical effect of emotional change in any living organism is usually in glandular function, and I would add emphatically, if sufficiently prolonged or repetitive, in glandular structure, functional change preceding eventual structural change. I myself would go so far as to extend this hypothesis to the whole field of organic medicine not excluding bacterial microbial infection, and to emphasise that, as we have learnt in recent years that stomachs do not go bad in themselves and arbitrarily develop ulcers, so we shall in due course find that no organs anywhere in the living organism behave in this unilateral fashion, but are all beholden to the emotional life of the whole organism for their functional activity, their structural change and their resistance or otherwise to invading enemies.

The essence of my hypothesis is that the morbid process begins with a frustration of sexuality on the reality plane, a frustration which is of course inevitable in the Oedipus stage of development but which may be greatly contributed to throughout life

thereafter, particularly at puberty. This frustration, whether caused by external or intra-psychic forces, such as super-ego, leads to a breaking of contact between the sexual drive and reality and results in the former expending its energy in phantasy or hallucination in order to relieve its tension.

I now wish to extend this hypothesis to all psychogenic disorders, psychoneurotic and psychotic, without exception, pointing out that the differences between the so-called varieties of disorder are essentially differences in degree of subsequent libidinal regression, a qualitative difference, and that the differences in severity of disorder are due not only to this qualitative difference, but also to quantitative differences in the relative amounts of libido which follow the regressive path.

On careful study it will be seen that such implications can almost be deduced from the classifications of neurotic and psychotic disorders based purely upon clinical or psycho-analytical evidences. For instance, when Freud divides psychogenic disorders into two main categories, those of (1) the "transference neurosis" and (2) the "narcissistic or paraphrenic conditions", he is unconsciously suggesting my hypothesis in that he has told us that according to his clinical experience certain illnesses, to wit the psychoneuroses, are more prone to libidinal transfers, that is to say *have a stronger contact with reality (in the shape of affective feelings towards another person)*, and that the psychotic conditions have less capacity for this reality libidinal contact called "transference". In other words, quantitatively at least a greater proportion of the latter's libido has retreated from reality into introversion.

"Abraham, Bleuler and Jung have all demonstrated that schizophrenia exhibits unconscious psychogenic mechanisms akin to those met with in the neuroses, and that the disorders manifested represent an introversion of interest accompanied by a regression of mental processes towards a more infantile type."¹

Since writing the foregoing conclusions I find that in the above-quoted article Dr. Ernest Jones says: "We are not yet in a position profitably to discuss the fundamental causes of the differences between the neuroses and the psychoses. . . . The most satisfactory formulation of them at present possible would seem to be that the introversion; or turning away of interest from

¹ Ernest Jones, *American Journal of Insanity*, vol. 69.

the outer world which is the most characteristic feature of both, has proceeded to a further degree in the case of the psychoses carrying with it a loss absolute or relative of the feeling for reality. In the neuroses the introversion essentially relates to the sexual hunger (*libido*), whereas in the psychoses there is present as well as this also an introversion of other interests with a relative abrogation, temporary or permanent, of the reality principle; whether this abrogation can be ascribed, as Freud seems inclined to think, to particularly complete introversion of the sexual hunger is a moot question in the forefront of interest at the present time."

I here claim that the clinical material placed before the reader in this and the preceding chapters is without exception circumstantial evidence in favour of the conclusion that in all cases this abrogation can certainly be ascribed to a "particularly complete introversion of the sexual hunger". I would say, further, that no other factor emerges from the clinical material as a precipitating or initial cause of the morbid process.

But my second hypothesis with which I am now concerned is that the psychoneuroses and psychoses not only have this initial factor in common, but that the differences between them and their various categories is qualitatively the fixation level which the subsequently regressing libido reaches, and the relative quantity of libido which so regresses. In other words, I would say that all psychogenic illnesses begin with this initial introversion of sexuality and differ only in the quality and quantity of the subsequent regression. One must add, of course, that no normal mind is free from some quantity, however relatively slight, of this introversion of sexuality and consequent regression of libido, and what is more, every normal mind has some modicum at least of every quality of libidinal regression and fixation. (After all, this should not surprise us, for on the physical plane we are familiar with every vestige of our phylogenetic and ontogenetic past.)

As a result of one's clinical experience, the impression is forced upon one that all minds, normal, psychoneurotic or psychotic, are essentially almost identical, or at least share identical mental mechanisms. In so far as, as a result of reality frustration or super-ego inhibition, libidinal contact with reality is prevented and in consequence the libidinal energy introverted, to that degree is a morbid process initiated; and no living

thereafter, particularly at puberty. This frustration, whether caused by external or intra-psychic forces, such as super-ego, leads to a breaking of contact between the sexual drive and reality and results in the former expending its energy in phantasy or hallucination in order to relieve its tension.

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person is entirely free from it. It will be appreciated that the greater the quantity of libido so introverted, the greater will be the tendency to regression and libidinal reactivation of earlier fixation points. It would appear on the clinical evidence that in the psychoneuroses the quantity of this morbid process is insufficient to lead to more than relatively slight loss of reality contact, whereas the psychoses differ from this in that the quantity of introverted libido is greater and the regressions both deeper and quantitatively stronger, resulting of course in a greater dissociation of interest from reality.

But within these general principles clinical evidence shows us certain refinements which we may tentatively bear in mind. Thus it would seem that in schizophrenia the libido has regressed to the very earliest fixation levels, including sometimes the earliest oral, or sucking stage, whereas in manic-depressive psychosis the libido, though following I think identical processes, including the initial introversion of sexuality, has not regressed further than the second oral stage (in psycho-analysis the stage of cannibalistic incorporation of the whole-object). Ernest Jones hazards the view that manic-depressive psychosis and schizophrenia "represent merely different stages and variations of a profound introversion rather than two entirely distinct disease processes". He goes on to say that this disorder, together with "other conditions, notably certain of the epilepsies, may profitably be regarded as representing intermediary stages, so far as the extent of introversion is concerned, between the neuroses and paraphrenia" (schizophrenia).¹ Urstein also reached the conclusion that manic-depressive insanity is to be regarded as a syndrome of catatonia.²

The impression gained is that all psychogenic disorders have much in common, and are essentially different stages of different degrees of reaction to environmental frustration and intra-psychic conflicts of various intensity.

I have myself had clinical evidence to indicate that in obsessional neuroses the qualitative regression of libido has mostly not gone back earlier than the later anal-sadistic stage (retention stage). For instance a very typical obsessional patient of mine told me that his illness had begun with his holding in his sexual function and confining it to phantasy, but had subsequently in

¹ *American Journal of Insanity*, vol. 69.

² Urstein, *Das manisch-depressive Irresein als Erscheinungsform der Katatonie*, 1912.

the course of time proceeded to his holding in his faeces instead of letting them out, and that this activity, a conflict at his anus of which he was physically aware, now absorbed almost the whole of his emotional interest throughout his daily life and made it almost impossible for him to attend to his work or any reality matters and caused him to be in a perpetual state of exhaustion as it took up so much of his energy.

One's clinical impression is that, once libidinal regression passes the line as it were between the later anal stage of retention and the earlier anal stage of expulsion, contact with reality becomes so gravely lost that the victim may be regarded as having passed the border between psychoneurosis and psychosis. The obsessional patient just quoted from often vacillated between the two sides of this boundary. One felt that if his massively regressed libido slipped to a slightly lower fixation level, *e.g.* that of the first, or expulsive, anal stage, he might easily have lost such contacts as he now possessed with the reality world and lapsed into irreversible schizophrenia.

Such cases, like a large proportion of the constitutionally predetermined psychotics and neurotics who come for treatment, are beyond cure, and we have to content ourselves with a little palliative utilisation of such portions of their libido which may still be utilisable, though often not beyond the realms of transference.

If the elucidation of the psychopathology of these illnesses leads us to take a gloomier view regarding the prospects of therapeutic measures, we may take consolation in the thought that it brightens considerably the prospects of prevention or prophylaxis.

If the psychological basis of schizophrenia and of all other psychogenic illnesses is laid down at the Oedipus level of development and is therefore impossible to prevent, it may at least be possible to prevent this nuclear basis receiving contributions through a succession of sexual frustrations during the rest of the individual's life. A point not to be lost sight of is that the removal of mere reality frustrations, whether or not desirable on its own account, would be no remedy, for the most specific frustrations are those promoted by the individual's own super-ego and ego. In short, the sexual instinct cannot be healthfully relieved of its tensions without the demands of super-ego and ego being simultaneously met or incorporated in the process. It is on this

account that we witness the attempts on the part of educators to encourage the developing child to get its satisfactions in substitutive or sublimated forms. Perhaps it is only when these substitutions or sublimations prove inadequately gratifying to the libido that a state of frustration can be said to exist.

The criticism from clinical psychology would be to the effect that while every effort is made to raise sexuality to a level that will satisfy super-ego and ego, however morbid these latter may be, no attempt is made to bring super-ego and ego down to a level when they would be satisfied with an even slightly modified sexuality. Perhaps it is this hardness of the heart on the part of the elders towards their children, if not towards themselves, which is the essential factor initiating the initiating factor in the causation of schizophrenia. Incidentally this may account in part for the repressed hatred which is invariably present in these cases.

I would add that schizophrenia and recognisable psychogenic and other disorders are but the manifestations of morbid undercurrents that, in some degree or other, vitiate the health and happiness of every individual member of the social organisation and result in the latter being as unhealthy a sociological growth as the individuals that comprise it are imperfect biological growths, the one acting upon the other reciprocally.

However difficult it may be to deal with these problems in a practical way during infancy and childhood, the task should not prove insurmountable when it comes to the great transitional period in developmental history, when the choice has to be made between the morbid introversion of pubertal sexuality and its satisfactory social-sexual expression in a real world. It is conceivable that if society can find a remedy for the sexual strains of the pubertal and post-pubertal years in such a manner that sexual expression would be both ego-syntonic and super-ego-syntonic, then it might well find that within a generation or so it had reduced very considerably not only the admissions to its mental hospitals, but also an astonishingly large proportion of its sufferers from ill-health, both recognised psychogenic ill-health and debilitating diseases and invalidism, of every description. The whole prophylactic problem still remains to be carefully and scientifically worked out in detail. All I have hoped to do in this connection is to indicate a basis, however revolutionary, and to stress the need for exact study

on the lines of clinical research. This preliminary essay is, I feel, rendered all the more necessary as the inauguration of a State-controlled medical service threatens to stabilise and render permanently sterile the present inadequacy, or rather erroneousness, of our current practice, and the misconceptions upon which it is based—to keep our modern scientific dark-age permanently dark and to forbid the much-needed access of the light of research and revolution.

To sum up: My hypothesis is that the morbid process in schizophrenia begins in a manner identical with that of all psychogenic disorders, namely, with sexual frustration and conflict resulting in repression of libido and activation of unconscious sexual phantasy with consequent introversion. The temptation to turn away from the struggle against frustrating realities begins at, or has its main incentive in, externally or internally (super-ego) frustrated sexuality, and if yielded to is the beginning of a protracted death during which the subject is temporarily endeavouring to avoid pain or to achieve gratification through a method of self-injected euphoria. Even if the process is incapable of leading to such a severe dissolution as that of schizophrenia in the course of one lifetime, this morbid reaction tendency can accumulate through the generations by a process of Lamarckian-like inheritance until its phylogenetic accumulation leads to all the pathological changes which we have been studying. The essential matter of interest to the psychologist is that it appears to be within the mind, and specifically in the neurosis-wide and world-wide tendency to frustrate and inhibit the sexual instinct, that the morbid changes are initiated. In the light of our clinical material and all these further theoretical considerations let us now repeat a conclusion which was suggested early in Chapter XX: *Introversion is really synonymous with unconscious sexual phantasy and this is the essence of the initial movement in all psychogenic disorders, including schizophrenia.*

SECTION V
TREATMENT

INTRODUCTORY

WHERE an illness, however mental its manifestations, is found to have its foundation in physical disorder, and where the precise nature of that physical disorder is thoroughly understood, physical methods may emerge which are specific, and a triumph for scientific knowledge. For instance, even the "staccato" writing of the General Paralytic may be cured completely in a little more than a week by a proper dosage of penicillin—or so it was claimed in the first flush of enthusiasm. Unfortunately, there are few illnesses with mental manifestations that can be traced to any specific infective or physical disorder, and *in the overwhelming majority of these cases* physical treatment is no more than empirical and of varying efficacy. Apart from this, practically every sufferer from a neurosis has certain concurrent troubles which manifest themselves on a physical plane, and for which he may demand and receive a variable amount of alleviation along the lines of ordinary, palliative, physical treatment. From the use of aspirin or phenacetin for headache to hyoscine and morphia for uncontrollable excitement, there is no denying the efficacy and utility of physical methods.

It is a very different matter when we endeavour to extend the field of chemical and physical treatment, as a specific, into the domain of psychogenic illness proper—in which alone lies the interest of the psychotherapist, and to which belong almost all illnesses with a predominance of mental and nervous manifestations.

Nevertheless, such attempts have been made—from the days when floggings (if this can be called a "physical method of treatment") were used for insanity, and (only a generation ago) the removal of a strip of the skull for microcephalic idiocy.

Modern methods are better rationalised, at least when they aim at specific, as distinct from palliative, treatment. Taking their cue from psychotherapy they are usually based on the theory that all effective treatment lies in the production of some form of *abreaction*.¹ This, they would claim, can be aroused by

¹ In my view the function of abreaction (not excluding the fits of electric convulsive therapy, of epilepsy and of insulin coma) is closely related to the function of the orgasm. This function is to provide an outlet for excessive accumulation of

external (chemical or physical) as well as by internal stimuli—this in spite of the fact that it is impossible to believe that any chemical or physical stimulus can be *specific* for the particular emotionally-charged complex responsible for the patient's condition.

These abreactive treatments, starting at the lowest, least organised and least specific levels, may be classified as follows:

(1) Treatments with no ego participation. These include, in addition to all chemical and drug treatments, electric convulsive therapy, insulin coma and, more recently, electro-narcosis. Some of the pioneers in these methods have already discarded them.

(2) Treatments which involve only a *part* of the ego. These include hypoglycaemia (a process of reduction of consciousness, not amounting to coma, by the administration of insulin), ether abreaction, with or without the addition of methedrine stimulation, and narco-analysis.

(3) Treatments which aim at utilising the whole ego. These last, which are not physical methods of treatment, include group analysis and psychodrama. The latter is a recent development from group therapy in which the group re-enacts a situation of emotional conflict with the patient whom the conflict concerns taking the leading rôle, or criticising its enactment by others. (The effort demanded of an introverted and anxiety-ridden patient may often prove greater than he can bear.) Though group treatment and psychodrama aim at the emergence and abreaction of more or less repressed emotions with ego co-operation, they utilise mainly the conscious levels of the mind and it is difficult to see how they can effect very much change in unconscious super-ego or any repressed constellations.

To counter our human tendency to wishful thinking and desire for magic, it may be as well to quote the remark of a colleague of mine who is engaged exclusively in the most recent physical methods of treatment in psychiatry, principally insulin coma and sopor (sometimes with the addition of electric convulsive therapy), and ether abreactions. He said: "One has to *experience* the application of physical treatment to realise its utter futility!" We may add to this observation that psychotherapists engaged in group treatment and psychodrama usually submit tension and thus to adjust the intra-psychic economy within the limits necessary for the maintenance of health.

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themselves sooner or later to a course of personal analysis. They do not choose to be treated or educated by any form of group therapy; and I have certainly never heard of a colleague who elected to subject himself to any form of physical treatment!

The various methods of analysis, including psycho-analysis, are the only known forms of treatment of which it can be said that, while they utilise the whole of the ego, they also aim essentially at bringing to consciousness as much as possible of the repressed unconscious. As the root of every psychogenic disorder is held to lie in the unconscious, this remains the only truly scientific method of treatment, the only method *relevant* to our current knowledge of psychopathology. On this account, the greater part of this section on treatment has been devoted to the analytical method.

CHAPTER XXIII

PHYSICAL METHODS OF TREATMENT: DRUGS, ETC.

(As all mental functioning as far as we know is dependent upon the functioning of body and brain, it follows inevitably that what affects the physical and chemical constitution of the body and its brain must also affect the mind,) and a physician whose special province it is to deal with mental or psychogenic disturbances cannot afford to shut his eyes to the possibilities of such manifestations being secondary to physico-chemical disturbance. (Nevertheless, mental or nervous symptoms which arise as secondary products of physical disturbance must remain within the province of ordinary medicine even if they become a special branch of medical practice. They will interest those who are particularly concerned with the chemistry, physics, biochemistry and bacteriology of the body, rather than the psychologist who has taken mental processes as his special province.) Fortunately for him cases of this nature do not too frequently come his way; more usually they are eagerly pounced on by his colleagues in general medicine, or by the psychiatrists who have made this branch of general medicine their speciality.

(Therefore the brief review of physical treatment which I propose to include in this book is more for the purpose of revealing the psychologist's attitude towards it, both his acceptance of it in appropriate cases, and his critical aloofness from it in what he considers to be its unjustifiable encroachments.

No claim is made that this account of physical treatment is comprehensive or in sufficient detail to satisfy the practice of it by the enthusiast. It may be said that those who are most competent in details of physical and chemical methods of treatment are in general not psychologists, however good they may be as physicians. On the other hand, there exists a tendency amongst those who are ignorant of physical treatment, such as the laity, to endow it with exaggerated magical properties to which nobody practised in this treatment would give credence. At the same time I have observed amongst certain physicians and psychi-

atrists a tendency to exaggerate belief in the powers of psychotherapy as striking as perhaps the more frequently-made disparagement. More than once have I sent a case who had proved unsuitable for psychological treatment, such for instance as a severe obsessional who tended to become mute and even somewhat schizoid under psychotherapy, to a psychiatrist for some physical treatment such as electric shock therapy, only to be told by him that he considered this a most promising case for psychotherapy and had little or no faith in his powers to do it any good.

Apart from the genes or inherited genetic characteristics of an individual with their presumed physical basis, every part of the environment which he meets both physical and mental from conception onwards, must have some influence upon his mental functioning, his impulses, tensions and symptom-formations.

Atmosphere: Even the conditions of atmospheric pressure and chemical composition cannot be excluded. With the exception of climatic variations, to which incidentally temperamental and neurotic persons are often particularly sensitive, under normal conditions atmospheric conditions are sufficiently stable to merit our ignoring them, but under exceptional circumstances, for instance in the case of the flying man, the alteration in his atmospheric environment at 12,000 ft. or more produces marked alterations in breathing with accompanying mental change. High speeds also produce marked mental changes even to the degree of complete blackout or unconsciousness. But apart from these unusual circumstances, perhaps the physical factor of *diet* deserves our first attention.

Diet: The innumerable artificial interferences without good reason of the natural dictates of appetite, popularly known as fads, may well be regarded by psychologists and public alike as being themselves symptoms, and suggest to me a mental mechanism characteristic of the neuroses. The psycho-analyst may implement these intuitive assessments of the dietetic crank with specific theories of oral cannibalistic phantasies concerning the introduction of "good" and "bad" objects, theories which may be extended in many cases to the benefits obtained from the doctor's (good parent imago's) bottle of medicine, the homologue of the original reliever of all distress, the mother's milk. Occasionally we see a patient whose super-ego has so pitted itself against instinct gratification that every variety of oral in-

dulgence becomes impossible, all food becomes a "bad object" and extreme degrees of emaciation result (*anorexia nervosa*).

This psychological criticism is applicable only in so far as dietetics is without adequate scientific basis, for it must be admitted that under the artificial conditions of civilisation certain dietary defects do tend to arise, though I think they are more generally due to a restriction upon appetite and diet than to a free and natural indulgence of it. These dietary defects have in recent years been shown to depend mostly upon various vitamin deficiencies.

Vitamins: Vitamin A deficiency, for example, has been related to night blindness, though I think the physician or psychologist who jumped to this conclusion in every case of alleged night blindness would make a considerably larger proportion of mistakes than the psychologist who had never heard of vitamin A, but invariably treated the symptom as an hysterical manifestation. Similarly, the absence of this vitamin and vitamin D have been said to cause night terrors in children. However true this possibility may be, it is undoubtedly true that the very vast majority of night terrors in children have nothing to do with any vitamin deficiency. With regard to nervous symptoms, deficiency of the vitamins of the B group, particularly B₁ and the B₂ complex, have been alleged to cause lassitude, insomnia, nausea, anorexia, depression, headaches, palpitation and a number of other symptoms more commonly of psychogenic origin. The nearest I came to conviction that a patient of mine suffering from these and other symptoms might have this particular physical basis for them was in the case of an elderly gentleman who was in the habit of constant slight over-indulgence in alcohol and who exhibited at the same time blackouts with collapse and an occasional absence of tendon reflexes in his legs suggestive of an incipient peripheral neuritis. His illness had been erroneously diagnosed as due to alcoholism and subsequently, when he became a teetotaller, as "catalepsy"—whatever that means. He was placed on large doses of vitamin B while he was undergoing psychological treatment. In due course he revealed an abundance of hysterical characteristics both current and aetiological and showed progressive improvement. After some months I was inclined to attribute this improvement to the vitamin B—only to discover that he had ceased taking it after the first week.

However, once having had an orthodox medical training, it is impossible to free one's mind entirely from its early instilled belief in physical methods, and I am yet ready to believe that there are cases of Wernicke's syndrome, not to speak of undiagnosable pellagra and other diseases with mental manifestations, which are amenable to cure by the sole remedy of correcting vitamin deficiencies. All I can say is, that in spite of years of hope I have never yet met such a one. Too lively a consciousness of the effect of vitamin deficiency is apt to mislead the physician along physical or dietary lines of treatment until he has wasted many years of his life in experiments which will eventually convince him of their futility. At the same time, I would say that there is no harm in prescribing all the vitamins if at the same time we recognise that symptoms are psychogenic and do not defer investigation or treatment along psychological lines.

Endocrinology: As the logical consequence of vitamin therapy we should perhaps say a word about endocrinology. There is no doubt that healthy mental processes are dependent upon well-balanced endocrine function. My only quarrel with the endocrinologists would be when it is empirically assumed that mental or nervous dysfunction is invariably the result of some endocrine imbalance, the aetiology of which latter is not investigated. It is commonly assumed by endocrinologists that thyroids, adrenals, pituitaries, gonads, pancreas or other sources of internal secretion are wrong *on their own account*, magically as it were, and that such a failure on their part does not deserve investigation but is accepted *a priori*. Having started with this premise, they immediately point to psychological changes as fully explicable as a result of the endocrine cause. I think such an attitude is a reversal of the general biological principle that a living creature reacts to its environment psychologically, and that its glands and their functions are but executive organs of the primary mental-emotional process. For instance, it is not because the cat's suprarenal suddenly discharges adrenaline into its blood that it jumps ten times as quickly and as far as it did a few moments ago. It is because it has seen a dog. The psychological reaction has been primary and has *produced* the extraordinary secretion of adrenaline by its suprarenal glands. If such experiences in a cat or human being were unduly repeated or prolonged whether from external environmental stimuli or

from internal endo-psychic phantasies, certain changes in those adrenals and related endocrine glands might result, perhaps such changes as alternating hyperactivity and exhaustion.

Thus one is inclined to say to the endocrinologist, "Please take a back seat and recognise that what you are studying is generally a secondary product of mental processes and not vice versa". The corollary is that if treatment is to concern itself with causes rather than effects it must be primarily psychological and not primarily endocrinological.

Thyroid: However, there are exceptions to this generalisation. The practitioner, physician or psychologist who misses a case of primary thyroid deficiency whether in an infant or adult is culpable of serious malpractice. The intellectual retardation in cretins is hardly remediable by any process other than the *adequate* supply of the missing thyroid substance. It is regrettable that one finds such few opportunities of performing this therapeutic miracle. Although it has been said that in cretinism and even in cases of myxoedema the benefits to be achieved by thyroid administration decrease rapidly and progressively after the disease has been in process for over two years, one still has grounds for some hope, both with older cretins and with the adult cases of myxoedema. It is hardly sufficiently recognised how many of such adults are missed by psychologist and physician alike, even where the signs are characteristic and diagnostic. This is much more the case, however, where the deficiency is slight and the signs are almost imperceptible, as, for instance, in rather plump women with frigidity and perhaps some degree of amenorrhoea and often some minor symptoms of mild anxiety state or incipient hysteria. Tentative doses of thyroid increasing even to the limit of tolerance may well be worth trying. It may be mentioned that, contrary to general belief, cases of this nature which actually put on a little weight under the treatment commonly receive the greatest benefit. Disappointment will be encountered when it is the pituitary rather than the thyroid which is at fault.

Administration of thyroid has other uses in psychiatry besides the treatment of cretinism, myxoedema and minor thyroid deficiencies. It is one of the few useful stimulants worth trying—provided our expectations are negligible—in small doses in cases of mild depression, though it has no influence on more severe cases of the manic-depressive group. Certain schizophrenics,

particularly those subject to alternations of stupor and catatonic excitement, are sometimes tolerant of enormous doses, even as much as fourteen grains a day, but the administration of thyroid to schizophrenics is not recommended other than experimentally and in asylum practice, as although their physical tolerance is great, mental results such as the provocation of unexpected excitement may be disastrous.

Perhaps its chief use is in those unfortunate anxiety neurotics who have fallen into the hands of a surgeon rather than into those of a psychotherapist, and have been subjected to thyrodeectomy. (One surgeon, recently deceased, is reputed to have performed no less than 20,000 thyroid operations and to have had the word "Thyroid" as his telegraphic address.) Where thyrodeectomy has been performed for anxiety states the victims' last condition is certainly worse than their first, for while they had their thyroid fully functioning they were in a far better position to cope with their anxiety symptoms than they are now in since its unjustifiable removal. We are reduced to administering by the mouth in the form of thyroid tablets the product, which they could previously themselves manufacture as a necessary basis of endocrine balance, before we are in a position to help them to deal with their psychogenic symptoms. It should also be emphasised that our dosage of thyroid tablets is arbitrarily determined, whereas in a properly functioning organism the production of thyroxine will be properly regulated and synchronised in accordance with the person's mental, emotional and physical requirements.

Adrenals: An endocrine deficiency which is almost as liable to escape notice as are minor degrees of thyroid deficiency is that of adrenal hypo-function in almost all cases of Addison's disease short of adrenal crisis. Recently I have had a case that emphasises this danger (albeit extremely rare). It is quite understandable that her doctor sent her to me under the impression that she was a fairly typical psychoneurotic. Her history and many of her symptoms were certainly very suggestive of a psychoneurotic aetiology. She was a woman of forty whose main symptom was complete amenorrhoea of five years' standing. Other symptoms were insomnia, palpitation of the heart, indigestion, continuous pain on left side of abdomen and groin, headaches, hypersensitivity to cold, loss of weight, mental confusion and extreme lassitude—all dating from about the time of the amenorrhoea

and becoming worse in the last twelve months. The outstanding points in her family history were those of nervous illness and tuberculosis. Her past history was one of infantile neuroses, general ill-health and sex-repression. Her present illness, specifically the amenorrhoea, seemed to have been precipitated in a manner suggestive of a psychoneurosis in that she attributed it to worry over her husband being called up for war service. Under her then local doctor she was treated for amenorrhoea with stilboestrol, without result. X-ray of the pituitary gland was negative.

So far the symptomatology, including the amenorrhoea and persistent pain in the left side of abdomen without physical signs, had suggested to her medical attendant the diagnosis of conversion hysteria, particularly as physical examination, including that of the central nervous system, was negative. In this case the physical examination should be stressed. The patient was emaciated in accordance with her story of loss of weight. There was marked tenderness near the lower pole of the left kidney. The blood pressure was low, 100/70, and on careful inspection she was found to have just perceptible darkening patches on the backs of her hands, near the bend of the elbows and about her neck, though they were not present inside the mouth. On questioning it appeared she herself had detected this darkening and declared that it was not there a year ago. In this case I recommended that the patient should be put in the hands of an endocrinologist for the purpose of investigating the physical aspects of her illness by means of blood sodium estimation, etc., and if necessary the institution of appropriate physical treatment, such as administration of desoxycorticosterone, etc.

In spite of what might on the scientific evidence be expected to prove a specific remedy amounting to cure, experience shows that prognosis had best be extremely guarded and anything but optimistic.

Pituitary dyscrasias such as Simmonds' pituitary cachexia cause disturbed function in almost all the endocrine organs, including the suprarenal, and may therefore show symptoms suggestive of Addison's disease.

Oestrin: The mental and nervous disturbances which accompany menstrual changes in girls and women, particularly in those who have been subjected to excessive oophorectomy (removal of ovary by operation), obviously have a physical endo-

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crine basis, and this may be the foundation also of certain post-pubertal dyscrasias. It is unfortunate that the endocrinologists have not yet been able to provide us with an exact scientific method of dealing with these on a physical basis. An even bigger problem is that of those homosexuals in which the practice is not merely facultative and where signs of feminine build in males and masculine features in females suggest a constitutional origin of their psychological inversion. It is particularly unfortunate that endocrinology has here been phenomenally unsuccessful.

Though there may be cases of nervous disturbance associated with ovarian dysfunction in which oestrin has its uses, I have met only one where success was at all striking, though several where it has been tried without appreciable or more than very temporary result. At its best one cannot see that anything comparable to nature's own method of regulating the balance between the various endocrine secretions can be achieved by the rather arbitrary injections of an arbitrary dose of oestrin. Such practices suggest to one the analogy of the March Hare in *Alice in Wonderland* treating his watch with an arbitrary dose of the best butter, a procedure which would appeal only to one who, unlike the genuine watch-repairer, was ignorant or neglectful of the intricacies of its works.

In short I would agree with one of our most recent advocates of physical methods of treatment in psychiatry when he says, "Glandular therapy in psychiatry is rather the hope of the future than the practical measure of today".¹ I would add: *provided* the endocrinologist will reorientate his mind to a recognition that (apart from genetics which man cannot alter after the fact) it is in the nature of things that psychological changes are primary, and logically precede endocrine change rather than vice versa, and that it is the failure to recognise this which vitiates the science of glandular therapy today.

Chemical Stimulation: To pass from glandular treatment to chemical stimulation, medicine and psychiatry have little or nothing to offer us. It would seem that mankind in general have throughout the world adopted certain measures on their own account, have as it were taken in hand their own treatment by the self-administration of stimulants. Apart from tea and coffee,

¹ Sargant and Slater, *An Introduction to Physical Methods of Treatment in Psychiatry*, p. 129.

the use of which is almost universal, there is the psychologically even more important practice of alcohol-imbibing. Surely this should be regarded as a generally, or at least very widely, adopted chemical method of psychological treatment. Normally it is related to a self-prescribed method of psychotherapy which may be called sociability. Instead of going to the expert, the majority of human beings deal with their woes, moods, psychological difficulties, etc., by two principal methods, the first being the going to one another, and the second, or chemical adjuvant, the imbibing of alcoholic liquors. They are not interested in the scientific details of the operation of these two methods, though such considerations may be worthy of a great deal more space than I propose to give them at the moment. While it is said that alcohol acts as a sedative to the highest cerebral centres, and while it is disputed that it acts as a stimulant to the lower ones, there is general agreement that it effects some alterations of the balance between impulse and inhibition, facilitating social relationships and intimacies and thereby enabling the "patient" to obtain some relief for previously pent-up tensions—without consulting the physician or psychologist. Admittedly when conflict is pathological the dosage may also reach pathological proportions, sometimes with disastrous consequences.

Apart from glandular treatment, practically the only chemical stimulant which the physician or psychiatrist prescribes that is worthy of a reference is benzedrine. This is admittedly a specific in narcolepsy, a disease which is rare enough to have eluded me in thirty years of practice. It has been said by some that it occasionally reduces the number of oculogyric crises, a post-encephaleptic sequela, though most neurologists prefer to try increasing doses of stramonium, and some of the most recent neurological books still say there is no treatment for this phenomenon.

Apart from these specific uses of benzedrine, it is reported to have a euphoric effect on most persons who take it and it is a general stimulant to the mind as a whole, temporarily increasing the person's confidence, talkativeness and initiative. Therefore it may be useful, perhaps more useful than tea or coffee, for those who require a temporary stimulant to brace them up for some special mental stress. Its disadvantages are that it leads to insomnia and, apart from that, it does not suit everybody.

Some psychiatrists have expressed great hopes for its future

in the treatment of delinquent children with cerebral dysrhythmia and consequent tendencies to spontaneous outbursts of aggression. But I think the wise physician if he uses it at all will combine its administration with that of a sedative such as luminal, and that any benefits obtained are as likely to be due to the latter as the former.

In general it may be said that the treatment of nervous or mental conditions by the use of chemical stimulants is more a practice of self-administration by the patients or public at large than an instrument in the hands of the physician, who is concerned more with ultimate than merely temporary or fleeting results.

Sedation: The use of sedatives in psychological and psychiatric practice belongs to a very different category and is of pre-eminent importance as compared with all other physical methods of treatment. I am, of course, excluding definite physical diseases which have secondary nervous and mental symptoms and where the appropriate treatment is naturally the medical treatment of the physical disease itself.

In general all chemical sedatives, hypnotics and narcotics are substances which have an inhibiting effect upon the oxidation of organic tissue. Experiments have been made outside the body, even with non-living organic matter, which show that their effect in reducing oxidation is exercised universally. Their special interest in medicine, especially in psychiatric and neurological practice, is that they appear to reduce oxidation of nervous tissue to a greater degree than that of other tissues of the body. In short, they produce a depression of brain respiration to a greater extent than the depression of tissue respiration in general. In consequence a new equilibrium is established. The body goes on oxidising practically at its normal rate, while the oxidation of nerve tissues is relatively lowered.

If nervous and mental illness were nothing more than a cerebral or nervous activity in excess of that of the body in general, sedation would be the specific cure for all these ills. But this of course is not actually the case. The principle of giving sedatives as a treatment for psychogenic illnesses might be likened to that of starving or partly smothering a population because they could not behave in a manner that was considered desirable by their controlling dictator. It is not a method of dealing with the problems, but simply one of reducing their activity by strangulation. The universality of its use in medicine

and psychiatry is an insignia of the bankruptcy and impotence of our precise or detailed knowledge of these abnormalities. If this is the best we can do we have certainly everything to learn. The awful fact remains that it is often the best we can do, and therefore we cannot afford to neglect a brief review of physical treatment by sedation.

Bromides: In spite of the only recently realised disadvantages of the bromides, tradition is so strong in this case that they demand priority of consideration. I am surprised to learn that the bromides were only fifth in order of frequency amongst the drugs prescribed in Great Britain, and were contained in only a little over five million national health prescriptions in one year.¹ I could hardly think of any particular chemical other than bicarbonate of soda which is more frequently contained in any and every prescription. The modern discovery that bromides can act only by the replacement of chlorides and that their effect is in consequence entirely secondary to chlorine intake and renal efficiency does not seem as yet to have affected their popularity with the practitioner. Added to these disadvantages there is the fact that in some individuals, and in almost all individuals if their administration is unduly protracted, symptoms of intoxication, usually unseen or disregarded, appear. As they are commonly the symptoms for which the drug was originally prescribed they are naturally more likely to lead to an increase of the dosage than a withdrawal. Psychiatrists have recorded that amongst patients admitted to hospital for the symptoms of sleeplessness, mental dullness, anxiety states and even delirium or stupor, were a fair proportion suffering from nothing more or less than the results of their own self-administration of bromide.

As against these published accounts² I should mention that I have met patients, particularly epileptics, at my own mental out-patient department who had been on as much as thirty grains of bromide a day, literally for decades, without revealing any symptoms of intoxication. In some cases where the drug was withdrawn in favour of luminal the patient objected and continued to complain until reinstated on his bromide. The theory of its function is that it acts as a cortical cerebral depressant, and I have noted that in epileptics who show, in addition to *grand* and *petit mal*, certain hysterical symptoms or emotional

¹ Sargent and Slater, *An Introduction to Physical Methods of Treatment in Psychiatry*, p. 85

² *Ibid.* p. 86.

difficulties, whereas the luminal may be given the credit for decreasing the frequency and severity of actual fits, the bromide has appeared to have a more specific effect on their emotional instabilities.

Barbiturates: However, apart from traditional standing, the barbiturates, in particular phenobarbitone (gardenal, luminal), are probably the most valuable chemical substance in all psychiatric and psychological work. Their value and practical usage will not be thoroughly understood unless one appreciates the importance of the recent discovery, through the agency of the electro-encephalogram, of the existence of the phenomenon of cerebral dysrhythmia. The whole subject of the epilepsies, their relationship to certain psychopathological conditions, particularly aggressiveness, as well as to slight aberrations of character merging into the normal, has been revolutionised by the discovery that 10 per cent. of the population show this non-specific type of dysrhythmia, or abnormal rhythms in the record of electrical activity in the cerebral cortex. The indication is that this is as near as we can get at present to the specific pathology underlying epilepsy and a number of related abnormal conditions. Nearly 60 to 90 per cent. of epileptics reveal the phenomenon, and though there may be no other epileptics in their genealogical tree there will most certainly be one or more, probably several, with undisputed cerebral dysrhythmia. There is some indication that this dysrhythmic condition follows Mendelian laws and the person manifesting an epilepsy is merely the one who has received an undue proportion of this apparently dominant character. Others may show no outward and visible sign of a pathological process, though it may break out under conditions of stress. Others again will show characterological traits such as impulsive and aggressive behaviour. Any psychologist who takes a careful family history will be struck by the frequency with which relatives of his patient, particularly mother or father or their relatives, whilst revealing no similar psychoneurotic breakdowns, are nevertheless eccentric in some particular, such as uncontrollable tempers or other aggressive manifestations. Statistics have shown that amongst the psychopathic the proportions of cerebral dysrhythmics are very much greater than amongst the general population. It may turn out that these two facts, the family history and the unrevealed cerebral dysrhythmias, are causally related, an interesting reflec-

tion for future investigation. The case related in this series of case-sheets under the title of "Hystero-Epilepsy" did not show the cerebral dysrhythmia characteristic of the epileptic, but he did show a non-specific type of dysrhythmia.

What may be of even greater importance than its significance for medicine is its significance for our law courts, and, indeed, for the whole hitherto unscientific basis of criminal law. One has long had reason to suspect that the majority of those who fall victims of the law are really psychopaths or mentally sick persons. Occasionally the perpetrator of some senseless or impulsive crime is shown to be a definite epileptic, and occasionally judges have been known to listen to medical evidence that this senseless act was performed in a condition of post-epileptic amnesia. But these are only a small minority of an abundance of cases which, while exhibiting the phenomenon of the senseless or impulsive act or aggressive behaviour, have no record of definite epileptic fits to exonerate them. The medical impression in the light of the revelation of cerebral dysrhythmia is that their senseless act was as much a symptom as is the fit of the definite epileptic.

The last time I was called as a witness in the law courts on behalf of a psychopath I observed the preceding case, a young man of twenty-one, receiving a prison sentence. He had quite senselessly in a public place attempted to attack a young woman, and the evidence was that after a rest in the cells when his father visited him he failed to recognise his father and made a similar almost murderous attack upon him. That is all I heard of the case, but I saw a young man with the facies, attitude and general appearance of a typical epileptic. Though there was no evidence that he had suffered from any definite *grand mal*, I was convinced in my own mind that there was only one explanation for the phenomenon for which he was being sentenced and that was the physical basis of cerebral dysrhythmia, a matter of which the courts have not yet taken any cognisance.

Hill and Waterson found dysrhythmia in 65 per cent. of aggressive psychopaths, Silverman in 80 per cent. of criminal psychopaths, and Sargant adds that "wherever the psychopath and the neurotic is encountered it is likely that dysrhythmics will be concentrated".¹

¹ Sargant and Slater, *An Introduction to Physical Methods of Treatment in Psychiatry*, p. 75.

Phenobarbitone: We are now perhaps in a better position to appreciate why phenobarbitone, long recognised as for all practical purposes a specific in the treatment of epilepsy, is so frequently helpful in a large variety of patients suffering from anxiety states and other apparently psychoneurotic disorders. Phenobarbitone is probably a specific, or the nearest we have got to a specific, for cerebral dysrhythmia. It therefore reduces the manifestations of those electrical abnormalities in the cerebral cortex whether such manifestations be epileptic fits, aggressive behaviour or anxiety resulting from excessive or stressful ego control and consequent tension from undischarged impulses.

It is a sign of the times, of the new outlook that medicine owes to psychopathology, that small doses of phenobarbitone are now regarded as more important in the treatment of gastric and duodenal ulcer and of gastric acidity than repeated neutralisation with ant-acids. One wonders how many other physical diseases will finally be admitted to have psychological causes, and physical treatment, if any, be directed to the organ of the mind rather than to its secondary effects in remote places.

The expression of life's impulses produces growth and reproduction with accompanying health and pleasure, whereas the repression of life's impulses, instigated by fear, creates a state of tension, anxiety and internal disruption—a biological equivalent of suicide. Psychopathologists have long recognised that one of the main causes of anxiety is a fear of unconscious impulses breaking out, particularly in cases where the impulses are such that the ego cannot deal with them except by a struggle to keep them repressed or suppressed. The ego's task, to find a suitable environment for the relief of such impulses, is particularly great if they are of an aggressive nature, or include an undue proportion of aggression. The cerebral dysrhythmic, if he is not an epileptic, is most likely to belong to this group of personality disorder. Phenobarbitone apparently helps to quiet down or lessen the electrical activity in the cerebral cortex which may be the physical source of his abnormal or uncontrollable p^tencies.

In addition to its apparently specific action in epilepsy or pathic than cerebral dysrhythmia, phenobarbitone sometimes greater than the effect upon a number of mysterious recurrent that these two bances from migraine and trigeminal neuralgia cerebral dysrhyth. not stopping the attacks it may, if taken

regularly, diminish both their frequency and severity) to dysmenorrhoea, anxiety states and hysteria and other psychogenic phenomena. The secret is to give it in very minute doses. Often half a grain at night is all that is necessary—and even this may prove to be too much. However it is worth trying in some of the above-mentioned recurrent disturbances, particularly migraine, provided we and the patient do not expect cure. It is not an infallible adjuvant to other treatment. Some patients are not better for it; some are even worse; others require three, four or more times the above-mentioned initial dosage to achieve any results.

Empirically it is all very well, but scientifically it is, of course, all very unsatisfactory. Results are so inconsistent in this heterogeneous group of functional ills, migraine to psychogenic disorders (excluding the epilepsies), that one is justified in wondering whether psychogenic factors play, unknown to us, at least as important a part as physical. Instances of the psychogenic factor at work are constantly presenting themselves to us though they must number only a small proportion of the cases where they are more important than we realise, where they operate but do not present themselves. Most recently such an instance forced itself on my attention and I shall record it here, as apart from such evidence this theory of the suggestive (psychological) effects of physical treatment is most difficult to support.

An elderly man who had acquired a considerable degree of positive transference to me, in spite of infrequent attendances, and required some nocturnal and diurnal sedation, was placed by me on half-grain doses of gardenal night and morning. He claimed enormous benefit from the drug, and being unable to attend for his next appointment wrote to me for the prescription. Unfortunately, luminal, though in the same dosage, was prescribed. When he telephoned to say I had sent him the wrong prescription, it was explained to him that the drugs were identical (both being proprietary brands of phenobarbitone). Nevertheless, he reported a month later that the effects were entirely different, that luminal had been worse than useless. He was immediately restored to health by reverting to his former gardenal prescription.

Phenyltoinum Solubile (B.P.C.) or Epanutin: Whereas phenobarbitone is supposed to act by exerting a sedative effect upon the focal source of the epileptiform disturbances, epanutin (a more

Phenobarbitone: We are now perhaps in a better position to appreciate why phenobarbitone, long recognised as for all practical purposes a specific in the treatment of epilepsy, is so frequently helpful in a large variety of patients suffering from anxiety states and other apparently psychoneurotic disorders. Phenobarbitone is probably a specific, or the nearest we have got to a specific, for cerebral dysrhythmia. It therefore reduces the manifestations of those electrical abnormalities in the cerebral cortex whether such manifestations be epileptic fits, aggressive behaviour or anxiety resulting from excessive or stressful ego control and consequent tension from undischarged impulses.

It is a sign of the times, of the new outlook that medicine owes to psychopathology, that small doses of phenobarbitone are now regarded as more important in the treatment of gastric and duodenal ulcer and of gastric acidity than repeated neutralisation with ant-acids. One wonders how many other physical diseases will finally be admitted to have psychological causes, and physical treatment, if any, be directed to the organ of the mind rather than to its secondary effects in remote places.

The expression of life's impulses produces growth and reproduction with accompanying health and pleasure, whereas the repression of life's impulses, instigated by fear, creates a state of tension, anxiety and internal disruption—a biological equivalent of suicide. Psychopathologists have long recognised that one of the main causes of anxiety is a fear of unconscious impulses breaking out, particularly in cases where the impulses are such that the ego cannot deal with them except by a struggle to keep them repressed or suppressed. The ego's task, to find a suitable environment for the relief of such impulses, is particularly great if they are of an aggressive nature, or include an undue proportion of aggression. The cerebral dysrhythmic, if he is not an epileptic, is most likely to belong to this group of personality disorder. Phenobarbitone apparently helps to quiet down or lessen the electrical activity in the cerebral cortex which may be the physical source of his abnormal or uncontrollable paroxysms.

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recent introduction to the pharmacopoeia) is supposed to act by reducing the conductivity of the surrounding nervous tissue, leaving the focus itself untouched, thus acting as a true anti-convulsant and not as a depressive. It is said to be the only drug used for epilepsy that will restore the encephalogram to normal. Although some claim that it will largely replace its predecessor, phenobarbitone, this claim seems to me doubtful as it presents certain difficulties in usage, its toxic dose being only slightly in excess of its therapeutic dose, and many will therefore prefer to use the safer and longer-tried remedy for dysrhythmia, unless of course epanutin should more than justify its claim for precedence. So far I have had little opportunity to push it, except in a few cases, to the extent of producing the rash, hyperplasia of the gums and other unwanted symptoms of toxic dosage, and am therefore not in a strong position to speak either of its advantages or disadvantages. I find however that most hospital patients to whom it has been introduced to displace gradually their regular dosage of phenobarbitone very soon ask to return to the latter medicament.

Sodium Amytal: Of the barbiturates sodium amytal should be mentioned as having a similar but more rapid effect than phenobarbitone. This gives it a special advantage in emergencies such as an air-raid warning or for a nervous person having to appear in court. In larger doses it can be used as an effective hypnotic where insomnia is due to anxiety or worry. When the drug first appeared on the market its dose was marked as 3 to 6 grains and, fortunately, before prescribing it I tried the effect of a 3-grain dose on myself. In consequence, I have since prescribed only 1-grain doses except in cases of very neurotic insomnia where patients have apparently been able to oxidise or eliminate it, possibly by reason of the physiological process of worry, more rapidly than I was able to. In these 7 grains has been required.

Medinal: Nevertheless, for insomnia in general if a drug has to be used I much prefer the older and well-tried remedy of medial—in $7\frac{1}{2}$ or 10-grain doses. It may be slower in its action but is reliable, and its effects do not wear off too quickly.

Continuous Sleep Treatment: Medinal is also useful in the only form of continuous sleep treatment which I, and many practitioners like me, have dared to employ. It can be used in 10-grain doses eight-hourly for a few days provided the patient is wide-awake for the next dose. If this dosage is inadequate one prefers

to supplement it with paraldehyde rather than to increase the dose of medicinal.

Regarding more ambitious attempts at continuous-sleep treatment, such as those which include the administration of hyoscine and morphia (drugs more appropriately reserved for violent deliriums such as delirium tremens), intramuscular somnifaine, large doses of sodium amyta, etc., even their keenest advocates and those most experienced in their administration admit: "... continuous narcosis has remained the most problematic of all methods of physical treatment in psychiatry and its results are the least predictable. . . . To use narcosis instead of more specific methods is, in depressive states, to inflict an unnecessary prolongation of the illness . . . the risks of sleep treatment are far from negligible . . . the danger period extends throughout the day and night."¹

Gillespie says: "The recovery rate in continuous narcosis in recent psychoses never exceeds and usually falls short of the ultimate spontaneous recovery rate. Its therapeutic value is, therefore, confined mainly to curtailing the duration of psychotic conditions which would sooner or later recover spontaneously."²

"It has been claimed that by adding insulin and glucose to the treatment by narcotics, the danger to life which attends the method (from collapse, respiratory complications, etc.), producing sometimes a death rate as high as 5 per cent., has been minimised."

"Continuous narcosis, if thoroughly carried out, is still fraught with some danger, in spite of modifications in treatment."³

Nevertheless, in modified forms continuous narcosis still has its uses in cases of acute panicky anxiety which are obviously inaccessible to psychotherapy and in any very excited and uncontrollable condition in psychotics. The more exogenous the cause (e.g. in cases of war traumata) the quicker the recovery. But these are in any case the patients who recover most quickly and most spontaneously with or without treatment.

Other Barbiturates: Other barbiturates in common use are soneryl, nembutal, proponal and somnifaine. The first-named has an action very similar to that of medicinal. I remember a physician superintendent of a large mental hospital who during

¹ Sargent and Slater, *Physical Methods of Treatment in Psychiatry*, pp. 100-103

² Henderson and Gillespie, *A Textbook of Psychiatry*, 6th Ed. p. 419

³ *Ibid.* p. 418.

an acute anxiety state went through the whole gamut of the hypnotics and finally settled down to a nightly dose of two tablets of soneryl (gr. $1\frac{1}{2}$ each), declaring that it was the only one which was effective and left him with no hang-over. This has not been everybody's experience.

Before leaving the subject of sedation one should mention the use made of these drugs in the experimental practice of so-called *narco-analysis* and *narco-hypnosis*. Nembutal, sodium amytal, evipan and pentothal sodium each has its advocates. The object is to facilitate treatment by temporarily drugging the patient's resistances whilst keeping him still communicative and communicable. As might be expected, those who have resource to these "aids" to psychotherapy are naturally those whose technique is most in need of aid. Gillespie says: "It is doubtful whether it ever leads the patient to disclose what he still means to conceal".¹ I have only found this method necessary in one case, and that was that of a girl of fifteen who suddenly discovered that the two-year-old baby she was minding was about to fall off the window-sill. She dived under the sash and caught it just in time . . . to find afterwards that she could not straighten the extreme torticollis which the operation had necessitated. Manual attempts to straighten her extraordinarily wry neck were automatically resisted and led to pain and screaming. When I saw her the condition was of only a few hours' duration and I seized the opportunity to prevent it from becoming established. The "narco-hypnotic" I used was simply the local dentist's gas apparatus and the symptomatic cure was complete in a couple of minutes.

In recent times the use of *ether inhalation* to induce emotional abreaction has had its advocates; and quite a lot of excitement can be provided by the injection of methedrine (30 milligrams in $1\frac{1}{2}$ c.c. of saline) when a patient is coming round from pentothal narcosis. However, the apparently lucid "recollections" and affective disturbances are followed by nothing more permanent than a cracking headache, happily of transient duration.

One can say that every method, chemical or otherwise, may have its uses—but not as a substitute for real treatment in cases which require genuine psychotherapy. The doctor who specialises in the treatment of psychoneurotics should be a psychotherapist first and an opportunist afterwards.

¹ Henderson and Gillespie, *A Textbook of Psychiatry*, 6th Ed. p. 421.

CHAPTER XXIV

PHYSICAL METHODS OF TREATMENT: CONVULSIVE THERAPIES, INSULIN AND PRE-FRONTAL LEUCOTOMY

HAVING reviewed in the last chapter almost the whole field of chemical methods of treatment in psychiatry, there remain a few other methods of physical treatment which I should mention, namely: *convulsive therapy*, *insulin treatment*, and that modified form of decerebration called *prefrontal leucotomy*.

Although these belong more specifically to the treatment of psychoses than to that of psychoneuroses (with the rare exceptions of some psychologically irremediable obsessional cases), it is necessary to make some reference to them, if only because so many psychiatrists have amongst their clientele a large proportion of psychoneurotics and have applied these methods, in lieu of more appropriate ones, in their treatment of the psychoneuroses.

It is not always the case that a physician is strongly biased in favour of the particular method of treatment, be it physical or psychological, which he has adopted and which he knows best. Very often the physical-treatment practitioner, and he alone, knows his own impotence. But like children and other impotent people, if he is sufficiently honest to recognise his impotence he prefers to believe that potency must exist *somewhere* . . . so it must be in the opposite camp!

Similarly the psychotherapist, knowing how inadequate are his own endeavours, takes consolation in the delusion that other methods have the key to the problem. Is not psychopathology identical in all, in patient and physician alike?

These are special instances of that same delusion which the ignorant patient nurses to bolster up his hopes (despite all experiences to the contrary) in the doctor and his bottle of medicine. 'Twas ever thus—magic is what suffering humanity demands; nothing less will satisfy them—from the time of the original witch-doctor to the inevitable bottle of medicine in every suburban practice . . . from Rudyard Kipling's Fakir (in

Kim) who wrote the magical prescription in Indian ink, which the patient carefully washed into a cup and drank, to the latest magical, and equally unscientific, extravagances of shock-therapies and leucotomies! In all persons, doctor and patient alike, the superstitious desire for magic makes inroads upon credulity whenever ignorance permits.

The strength of these tendencies alarms me when, for instance, I see such an "earnest, eager and self-confident physician"¹ as S. H. Kraines of Chicago, now a Captain in the U.S. Army Medical Corps, revealing in his prefaces some little evidence of the very mental fault (repetition of the orthodox and traditional mistakes) which he has compiled a monumental work to refute (*The Therapy of the Neuroses and Psychoses*). For instance, in his preface to the first edition he formulates three steps in the progress of psychiatry: the first (he says) is Kraepelin's classification, the second Freud's dynamic concept. ("All psychiatry today has been influenced by his dynamic concept. Freud, however, elaborated upon this basic concept a vast superstructure which many psychiatrists, including the author, regard as extremely fanciful."²)

Dr. Kraines goes on to say: "The third step in the advancement of psychiatry came with the advent of the shock therapies. These shock therapies have given impetus to the general understanding of the physiological nature of the body-mind, and to the specific nature of insanity."³

I suffered a little shock myself when I read this last statement. It only goes to show how one of the most individual investigators and thinkers can have his judgment (temporarily only, I hope) over-ridden by the ancient and modern craving for magic. Does any shock treatment help us to understand the body-mind and the "specific nature of insanity", any more than a crack on the head! But when Dr. Kraines goes on (in his preface to the second edition) to tell us that he has now included a chapter on the Shock Therapies and "To provide space for the new material I have deleted the chapter on Psychoanalysis and Related Schools", one wonders whether science is again being tempted to grab at magic at the expense of investigation and consequent

¹ Adolf Meyer in the foreword to *The Therapy of the Neuroses and Psychoses*, by S. H. Kraines, 2nd Ed.

² S. H. Kraines, *The Therapy of the Neuroses and Psychoses*, 2nd Ed. p. 5.

³ *Ibid.* p. 6.

orderly and scientific progress. Perhaps Dr. Kraines did well to delete his chapters on Psycho-analysis and Related Schools. Having only his second edition I am unable to read what he wrote about these, to him, extraneous subjects. Still I am disappointed. He is an interesting young man and I would have been interested.

However, perhaps I too have something interesting to say on these subjects. Scientifically, the shock treatments *teach* us very little or nothing beyond that which concussion, the epileptic fit and the phenomenon of suffocation have already taught us. I should think the physiological phenomenon of orgasm would be far more worthy of study both physically and psychologically. Indeed here we have a *natural* and recurrent internal cataclysm, or shock, the study of which (ever neglected by science) might really yield fruit.

As regards Dr. Kraines' airy rejection of all but the most basic of Freud's concepts . . . apparently in favour of shock therapy: I can only say that I am as individualistically and critically minded as Dr. Kraines, as perhaps my assessments based on some experience of the various physical remedies may indicate, and yet I can say that the more I have studied by clinical methods the spontaneous workings of the human mind (refraining from the introduction of extraneous shocks verbal or electrical), the more amazed have I become at the extraordinary accuracy of Freud's original work—not only of his basic concepts but equally truly of his most elaborate and incredible "super-structures". The only pity I have found is that they were not vast enough—as yet—to embrace every phenomenon and to provide a complete understanding of the whole field of mental functioning or inter-related mental (as distinct from physical) laws. I can only hope that in the fullness of time and with ripening experience Dr. Kraines' earnest and honest desire for understanding will lead him along the same path and perhaps to the same conclusion. However, in this part of the book physical methods of treatment are our special province and shock therapy as the present zenith of physical methods deserves sober consideration.

In spite of a great deal of bias and exaggerated views it is now being generally accepted by physical-treatment advocates and psychotherapists alike that shock treatment has its uses in specially selected cases and that these uses are limited to a fair

possibility of shortening a current attack of mental illness—though unfortunately having no influence upon the likelihood of relapse. A well-balanced account of its merits and demerits together with the usually neglected psychological implications is given by Dr. Cyril Wilson in his paper "An Individual Point of View on Shock Therapy".¹

I have treated by psychotherapy a large number of patients who had previously had shock treatment at another's hands, and in the vast majority there was no doubt (1) that immediate improvement (though not cure) had been achieved, and (2) that this improvement had not been maintained. Each patient I treated was as bad when he came to me as he was before he had the shock treatment. I got a marked impression from these patients that they were not as easy to treat psychotherapeutically as those who had not been subjected to shocks—though whether this was due to the nature of the case or the shock it is impossible to prove. My personal opinion is that it was the latter.

In the present state of our knowledge convulsive therapy should be reserved for psychotics, especially depressive states, such as involutional melancholia, and only for such psycho-neurotics who are quite inaccessible to a psychological approach—with perhaps the sole exception of a few very severe cases of obsessional neurosis who are failing to make any progress under psychotherapy and who are finding life pretty intolerable.

Convulsive Therapy: Though as long ago as 1798 Weickhardt recommended a treatment by pushing the dose of camphor to the point of producing vertigo and fits, it was not until 1933 that von Meduna of Budapest prescribed intramuscular injections of a 25 per cent. solution of camphor in oil to abort schizophrenic symptoms. It was a purely empirical guess based on a very doubtful observation that epilepsy rarely occurred in schizophrenics and that there might therefore exist an antagonism between the two diseases or symptom complexes. The form in which he used it was that of pentamethylentetrazol, otherwise leptazolum (B.P.), better known under the trade name of *Cardiazol*.

This treatment was seized upon by psychiatrists all over the world, in the optimistic hope that at last a sovereign remedy had been found for the intractable cases of schizophrenia which

¹ Cyril Wilson, "An Individual Point of View on Shock Therapy", *International Journal of Psycho-Analysis*, vol. 24, parts 1 and 2, p. 59.

comprised more than 50 per cent. of the asylum population. In spite of a considerable percentage of almost immediate improvements effected, the first optimistic hopes were not maintained. It was found, however, that a more useful application for this treatment lay in depressive disorders, though to some extent its use has continued in the treatment of schizophrenics also. In a large American survey 1000 schizophrenics treated with cardiazol convulsions did not do as well as an equal number of untreated controls, and nothing like as well as an equally large series treated by the insulin method.

It was soon noticed that certain disadvantages frequently accompanied its use. Gillespie says, "of sixteen cases treated with convulsants a test confirmed the impression of organic intellectual impairment in eight of the patients, though two of these did not complain of any disability".¹

"The risk of memory impairment suggests that convulsants should not be employed, except as an extreme measure, in patients whose livelihood depends on their memory and pure intellectual capabilities."²

Amongst the physical disadvantages vertebral fractures were the most frequent, though the evidence for these in most cases was entirely radiological. One of the commonest dangers is the lighting-up of a pulmonary tuberculosis.

Substitution of cardiazol for other convulsants, such as triazol and picrotoxin, led to no special advantages until in 1937 Celetti and Bini introduced their method of producing fits by passing an electric current through two electrodes placed on the patient's forehead. This had the advantage of convenience and comparative painlessness. The initial current used, for which the apparatus has to be specially set, is that of 80 to 100 volts with a 0.2 second period. If no fit is obtained the voltage is advanced a step and another shock given, but only when respiration has returned to normal. If this is insufficient the time-switch is advanced to 0.3 second, or even a larger dose may be required. The effect of the treatment is certainly electrifying to patient and attendants alike. Apart from minor effects such as stunning, which are not usually desirable, the typical sequence of events is: first, a momentary rigidity with instantaneous loss of consciousness, followed, after a brief latency period, by a violent

¹ Henderson and Gillespie, *A Textbook of Psychiatry*, 6th Ed. p. 408.

² Tooth and Blackburn, *Lancet*, 1939

fit almost identical with that of a major epileptic convulsion. A gag has to be inserted in the mouth and the patient prevented from injuring himself, particularly by spreading the legs, and by other extreme muscular contractions. After a variable number of minutes the fit subsides and it is some little time after that that the patient regains consciousness. Occasionally a patient is quite crazy, or even maniacal for several minutes after recovering. Usually there is apparent amnesia for the whole process, including very often events which immediately preceded the shock. Nevertheless it is extraordinary how often a patient sooner or later begins to dread the next treatment, suggesting that at least some modicum of the agony witnessed by the attendants has been registered at some level of his mental apparatus. In fact, I know of some unanalysed psychotherapists who, when their technique does not permit them to proceed further with their patient, find a ready and convenient way of getting rid of him by this simple prescription. I do not know how conscious or unconscious may be their motivation.

It is usual to give the treatment two or three times a week and to continue for as many as a dozen treatments or more, but my own experience is that unless a patient shows improvement within four or at least six treatments, the pushing of the process further is unjustifiable. Further, I would say that whenever a good result has been obtained, even if it is after only two or three treatments, it is best to leave well alone and discontinue. Unfortunately, I do not think this is the usual practice.

Undoubtedly considerable benefit is obtained in some cases. Thus Gillespie records that in 30 cases of involutional melancholia treated by him 19 made a good recovery and 5 improved, while in 98 depressives of the manic-depressive type 45 recovered and 28 improved. Results with schizophrenics are not nearly so good, and the relatively small percentage that show improvement frequently relapse into their former condition, possibly to reach a remission in the ordinary way at a later date. Comparison with control cases suggests that shock therapy makes little or no difference to the ultimate prognosis. Gillespie says that in all forms of nervous and mental disorder he prefers to use conservative measures to start with, and considers it better to defer any shock treatment programme while there is a reasonable chance of effecting recovery without it. On the other hand, he considers it unjustifiable to make a patient submit to

the prolonged misery of depression with its accompanying risk of suicide or exhaustion without resorting to electric convulsive therapy, even though recovery may not be effected.¹

Insulin Treatment: An even more important form of treatment in which also coma is the basis, is that of insulin therapy. Since the discovery of insulin by Banting and its specific use in the treatment of diabetes, a possible value in psychiatry has been suggested to improve appetite in cases of anorexia and to minimise withdrawal symptoms in the treatment of morphine addiction. But Sakel of Vienna was the first to utilise it for the production of hypoglycaemia as a treatment for schizophrenia. The technical difficulties involved in this form of treatment and the extraordinarily high standard of skill required by doctors and nurses administering it, limits its usage to special institutions well staffed with experienced personnel. These should be able not only to carry out the technique but also to give post-graduate students and nurses the required amount of training and experience so that it may become possible to establish an adequate number of treatment centres.

Full details would be inappropriate in a work such as this. The contents of the emergency tray required to prevent fatal accidents and the use thereof provide almost a special study in themselves.

Put as briefly as possible, the treatment might be outlined as follows. The patient, having been put to bed and placed upon a constant diet, the first dose of insulin, usually 20 units, is given intramuscularly in the morning after the patient has fasted for approximately eleven hours. This dose is increased by the same amount, 20 units, *each day* until the patient passes into a state of stupor.² This may be defined as a condition of the loss of normal response to speech and impairment of orientation, but a retention of the capacity for some purposeful responses in spite of the patient being somewhat confused. After this, increments of the daily dosage must be very slow and cautious until such time as coma proper has been induced. Coma consists of a condition of no responses to any form of stimulation except a painful one. When the stage of coma has been induced, the object is to find the *minimum* dosage necessary to cause its recurrence. Eventually the regular daily dose may be stabilised at half the

¹ Henderson and Gillespie, *A Textbook of Psychiatry*, 6th Ed. pp. 409-10.

² The term "sopor" is used by some writers.

most empirical.¹ It was introduced in 1935 by a Portuguese surgeon. It consists in an operation performed with a blunt needle-like instrument to sever the nerve association paths between the frontal lobes and thalamus. These nerve fibres are supposed to convey relationship between the supposed seat of the intellectual faculties in the frontal lobes and the emotional centres in the thalamus. The ordinary brain needle which is used for the purpose has a side eyelet and a close-fitting style. The coronal suture of the temporal bone is reached by a resection of skin and tissues behind the lateral margin of the orbit. A small burr-hole is then cut in the line of this suture, exposing the dura mater. The needle is directed into the brain substance so as to pass in front of the anterior horn of the ventricle, but not so far as to reach the grey matter on the medial aspect of the frontal lobe. The stylet is then withdrawn and the needle pivoted so that it cuts through the brain substance moving towards the upper surface of the frontal lobe. At the same time it is pushed more deeply into the brain substance. It is then withdrawn and reintroduced so as to cut the fibres from the lower part of the pole of the frontal lobe. To do this it is passed downwards to a point just short of the side of the skull. This operation has, of course, to be performed on each side of the brain in turn.

It is claimed for this treatment that symptoms are improved, with a restoration of appetite, weight, energy and interest, though even its best friends do not claim that there can be any improvement in the personality before the onset of the psychosis. At the same time it is admitted by most persons with experience of these cases that the patient thereafter tends to live a more *simple* mental life, even if he is somewhat relieved of emotional stresses and tensions such as self-consciousness. It is freely admitted that he commonly gives less trouble to those who have to manage him. It would seem that this claim may be called in question in view of the frequent undesirable sequela of incontinence, not to mention epileptiform attacks, aphasia and in some cases even dementia.

In recent times there seems to be developing a preference amongst physical-treatment advocates for experiment in the use of *electric convulsive therapy while the patient is under insulin-induced sopor*. Sometimes a *double E.C.T. shock* is tried, the second one

¹ Since writing the above, an even more drastic mutilation of the brain, namely, *lobectomy* (the actual removal of a lobe), has been experimentally tried.

being imposed before recovery from the first is complete. Danger of collapse or of irreversible coma is usually averted by the immediate administration of intravenous glucose. It is claimed for this desperate measure that some otherwise recalcitrant patients are improved.

The experimental practice of "*massive*" *E.C.T.* (three or four shocks a day for three or four days) will happily be discontinued in the light of further experience.

The use of *electro-narcosis* in which by means of a special apparatus, 120 milliamps., reducing to 60, are introduced into the brain for several minutes accompanied by the inhalation of oxygen and carbon dioxide for the resulting apnoea, is too recent for the assessment of results, but it seems to indicate the resourcefulness of the non-psychologically-minded therapist.

Regarding the shock treatments in general, and prefrontal leucotomy in particular, I would not go so far as to declare, as did one of my incensed colleagues, that if the advent of convulsive therapy has not placed an adequately lethal weapon in the hands of the would-be exterminators of all psychotics and psychoneurotics, the advent of prefrontal leucotomy has certainly filled their long-awaited, albeit unconscious, need. Nowadays anybody who understands sufficiently little of the principles of mental functioning and the nature of psychogenic illness, and who nevertheless professes to be a psychiatrist, has a ready weapon to hand with which he can do enough, indeed everything short of somatic death, to implement his ignorance and conceal his crime! The only remedy he could see for this ghastly state of affairs was that an outraged public should arise and perform decapitation, in return for decerebration, upon the Himmlers of their psychiatric Buchenwald!

On the other hand, I would agree with the majority of those best qualified to judge, that such drastic and empirical, if not arbitrary, interferences with the physical basis of mind are hardly justifiable in the present state of our knowledge except for cases where there is no reasonable hope of spontaneous recovery, and where either complete disablement or an indefinitely prolonged and unendurable agony are the only alternatives. However satisfying these drastic interferences may be for the psychiatrist and operator, this alone must not be allowed to justify the extension of their field of operation.

CHAPTER XXV

PSYCHOLOGICAL METHODS OF TREATMENT: THE IMPLEMENTS OF TREATMENT

SOME might consider that psychological treatment has a priority in medicine in so far as it might be regarded as beginning with the witch-doctors (part doctors, part priests and prophets) of the tribal life which marked the birth of culture. Others might prefer, perhaps disparagingly, to date its beginning to the advent of Mesmer (about 1778). Again, I have heard it said that Christ was the first psychotherapist, for His healing remark, "Brother, thy sins are forgiven thee", reveals appreciation of the fundamental relationship of guilt-feelings to the aetiology of disease, and His use of the term "brother" shows His knowledge of the therapeutic value of love and transference.

Psychological treatment, in a wider sense, might be regarded as being as old as the hills and at least as old as any physical treatment, for every word spoken by one person to another and every influence of one person upon another has some psychological effect—for better or for worse. When we confide our troubles to a friend or stranger, we are using him hopefully as a patient may use a psychotherapist, and when we listen to another's troubles we are, I hope, functioning as a psychotherapist for the other's relief and benefit. Even children talking together are already doing no more and no less. Similarly, the *activities* of play, the dances, war dances, rituals and religious rituals of savages and civilised may be regarded as self-devised "occupation therapy". The same applies to practically all the behaviour of all persons, individual and general. Though these conversations and activities are generally dignified by the term "psychotherapy" or "occupation therapy" only when they have the specific conscious purpose of alleviating the individual's sufferings and symptoms, the transition from the unconscious operation of such influences to the intentional direction of them for therapeutic purposes must in the first instance have been imperceptible.

In modern times the general practitioner who listens to his

patient's complaints without saying too much is, whether he knows it or not—and he generally does know it—acting psychotherapeutically. When he progresses from this passive rôle to that of offering explanation or advice, or consolation, or even diagnosis, physical or otherwise, there is no doubt that one of the rôles he has assumed, usually the essential one, is that of psychotherapist. All the more reason, therefore, why he should devote a little special attention to this much-neglected branch of medicine, and orientate his concepts and methods in the light of modern knowledge. In view of the great advances of medicine in other fields, I personally consider this incumbent upon him, and particularly upon the planners of the medical curriculum, if the art of medicine is to advance in this, the most used and usable of all its specialities, beyond the stage of the oldest, unconscious methods of psychological treatment, beyond the stage of witch-doctoring.

For descriptive purposes and to bring some order into our conception of the art of psychotherapy, we may divide the theory of the methods in use roughly into three main divisions. The first would be psychological methods directed at the most superficial levels of the mind, such as appeals to reason, intelligence, logic and conscious processes in general. The second would be methods directed specifically at emotional levels, such as suggestion, auto-suggestion, persuasion and hypnotism. The third main division would be methods purporting to expose the unconscious emotional levels, to obtain insight into them and their operations, and specifically to bring them under the jurisdiction of the conscious levels either with the purpose (*a*) of denying their needs and endeavouring to substitute alternative gratifications—under this heading I would be inclined to include faith, beliefs, morality and religions in general together with methods which place an undue emphasis on sublimation—or (*b*) of a due recognition of their needs within the realms of the requirements of reality and the social order, thereby giving the patient a practical possibility of emotional readjustment and cure. Under this heading I would include all methods of analytical psychotherapy.

There are no rigid lines of demarcation either in theory or practice between these main divisions, nor between the various methods rather arbitrarily placed under each main heading. For example, persuasion, which I have later placed under

division one, might be supposed to belong to this group in so far as the therapist insisted that in his persuasion he was using exclusively a process of reasoning or appealing to the patient's intelligence. Or, on the other hand, it might be placed under division two on the grounds that any effectiveness of the persuasion method is more likely to be the result of some, perhaps unconscious, emotional appeal than due to any strict operation of the intellectual faculties *per se*. The same might be said of all methods included under the first heading however much their operators might insist to the contrary. Similarly, faith, religion and morality might be held to belong more properly to the second division rather than to the third, depending upon the extent to which emotional urges are unconsciously utilised in the one case or consciously recognised and stressed in the other.

To examine these processes in a little more detail before we pass on to their most advanced and scientific development, namely that of deep analysis:

I. METHODS DIRECTED TO THE CONSCIOUS LEVELS

(a) To start at the surface, or perhaps above the surface, we might mention attempts to cure the patient by *changing his surroundings* rather than by attempting any change whatsoever in himself. This is usually a resource of those who are quite impotent in the psychological field, or/and cannot devote the necessary time and trouble to the case. It is commonly forgotten that the activities of normal people constitute essentially a self-prescribed therapy by this method of adjusting reality to one's needs, and that the self-prescribed prescription is the only appropriate one. The patient's illness is due to his psychogenic ineptitude in this respect. The time-honoured device of sending a case of nervous breakdown away for a cruise round the world or a holiday—as far as possible from the physician—has not yet fallen into the complete disrepute which it deserves. I should here confess that I myself have been guilty of experiments in this method when it was impracticable on account of pressure of time, the patient's and his family's inclinations, etc., to do anything else, and also in cases of psychosis where I felt that unfavourable developments were likely to accrue. The best result I have obtained is improvement during the holiday and a relapse soon after resuming work or re-entry into the previous environment.

Permanent changes of environment might in rare cases have a more lasting effect; but here I am reminded of the instance of the paranoid wife, and the devoted husband who took her dissatisfactions literally, and naturally tried the direct method of amending them. When the home he had purchased for their initial marital bliss proved unsatisfactory to her, he sold it and bought another according to her choice. This process was repeated several times until at last it transpired that what she really required for her permanent happiness was a house with a river running through her garden. Sacrificing the last of his resources he was able finally to gratify her wish; but alas! the disease, being of course psychogenic and not environmental, progressed further until finally no other adjustment has proved possible than that the unfortunate lady should live through her unhappiness in the only appropriate environment—that of the mental hospital.

Regarding changes of family or business environment, etc., the wise physician will not rush in with advice, for the results will probably be unsatisfactory and may be laid at his door. It is usually far better that the patient should receive psychotherapy until he acquires such insight as will cause *him*, himself, to make the necessary changes. There are, of course, certain instances where an unhealthy method of life is so obviously responsible that the doctor can hardly refrain from investigating it and suggesting some alternative—for instance, in the case of a depressed woman physician who was carrying the burden of an over-loaded practice on her young shoulders, and was unable or unwilling to find time for social or any other forms of recreation until she had reached a point when emotional breakdowns were erupting into her otherwise assumed serenity. I not only told her that she could not afford to ignore indefinitely her instinctual needs and her repressed desires for self-gratification, but I categorically ordered her to join a social tennis club and to take two afternoons a week off for this purpose.

In general, however, one has the impression that a person's surroundings and his way of life are usually *symptoms*, not *causes*, of his intra-psychic condition, and to direct attention to the former rather than the latter is beside the point and therefore doomed to failure. It is the resource of most of us in our psychological ignorance.

(b) *Appeals to Will Power:* This is the most superficial of all

psychological methods and is freely employed in the form of "pull yourself together" by all the patient's relatives, friends and enemies—usually to the patient's exasperation, further strain and deterioration. Combined with a certain amount of appeal to intelligence and reason many eminent physicians are almost equally culpable, though the advantage of their authoritative position may in certain instances, though very rarely, have some little beneficial effect to balance the more frequent harmful ones.

The reassuring effects of this method will not be under-estimated. What will be under-estimated is its impotence in the vast majority of cases. I am reminded of one eminent neurologist who, like all neurologists, sees an undue proportion of psychogenic illnesses sent to him by physically-minded practitioners. His unfailing method after doing a complete and sterile neurological examination, is to seat the somewhat bewildered and exhausted patient opposite him at his desk and then, after a duly impressive silence, to say to him very emphatically: "**You have nothing whatever the matter with you. Go away and do not continue this nonsense any longer.**" (Why does every experienced psychotherapist rock with inward laughter when he hears of this?) I know of one shattered victim who had his next, and worst, anxiety attack with vertigo and collapse, in the street outside the great man's door.

(c) *Persuasion*: A less brutal method of reassurance and appeal to will-power is the method of discussion and persuasion worked out in some detail by Dubois, in which, after devoting a certain amount of time to an investigation of the psychopathology of the case, it is explained to the patient in a rational way why he has got his symptoms and that they are quite unhelpful and unnecessary. Appeals are then made to his insight and to his reason as an intelligent person. It is astonishing how ineffective this method can be, which may bring it home to us on reflection, if we do not already know, what little power intelligence has in the motivation or control of psychogenic illness.

(d) *Anamnesis and Discussion*: It is extraordinary what a lot of satisfaction a patient can achieve at the first interview by his complaints being carefully listened to with infinite patience and by the taking of a fairly complete case history embracing the environment of his early life. Some patients in particular are most

anxious to talk it out. If the therapist will listen carefully and patiently, and think at the same time as he listens, he will probably achieve at least an initial understanding of the patient's illness. He may increase this understanding by an extension of the patient's opening remarks, of his initial formulation of his symptoms and complaints. Further, he may ask the patient to dilate upon various important points noted during his taking of the case-sheet questionnaire. For instance, matters relating to father- or mother-fixations, early and current sex life, traumata, such as recent or remote bomb experiences, and particularly a full description of current worries. Often a protracted talk will reveal to the physician odd attitudes of mind, such as paranoid trends on the part of the patient. But whether the physician is merely listening, or whether he is drawing more out of the patient, he must at the same time always keep an eye on transference possibilities, not only in case it should become necessary to proceed, at a later date, to analysis proper, but also to maintain himself in a position to influence the patient, for instance by advice.

A doctor in the provinces who used to send me the impecunious nuisances of his practice, for the purpose of one such protracted interview, was in the habit of referring in his letter to my "chit-chat" treatment, which reminds me that the benefits really achieved in *any form* of psychological treatment, whether chit-chat or analytical, are solely due to the emotional relief of a transference situation—the absence of an appreciation of which was humorously brought to my attention by this doctor's use of the term "chit-chat". Such transference situation at a first interview is achieved as much by the physician's understanding—which in some intangible way many patients are able to sense—as by his patience and evident interest in listening to all that is said, and by the thoroughness of his case-taking, supplemented in some cases by the physical examination and relevant comments. The most sensible patient should be able to go away after such an interview not feeling, as he may have done before the interview, that he was to see some pretender, or be subjected to some hooey, but feeling that, perhaps for the first time in his life, he had encountered a really sincere, understanding and painstaking physician.

Moreover, if this type of interview is sufficiently long or repeated on a succession of occasions, certain matters in the

patient's current life which he had not taken into account or had misunderstood will probably become elucidated with, or without, the direct help of the physician. For instance, a newly-married lady came to me in an extremely unstable emotional condition, bursting into inexplicable tears when she spoke of her marriage and the intense love she felt for her husband. She thought there must be something very much the matter with her; and why this new-found happiness should have brought it out when she was quite well and stable before, she was completely at a loss to understand. When asked for an instance of her alleged "stupidity" and "unreasonableness", she said: "Well, the other day my husband's sister invited him to tennis without asking me, and when I heard of it, I flew into a temper and then burst into tears. It was so silly. She had simply *forgotten* that he was married or that I played tennis—in fact far better than the middle-aged spinster she had asked to make up the four. Anyhow, it could not be altered. But she did then suggest that I should go and watch them." It further transpired in the course of the interview that this husband, who thought his wife perfect before their engagement, had since taken to a curious form of schooling her kindly in preparation for her new social obligations, even to the extent of suggesting the sort of clothes and hats she should wear, how she should pronounce certain words, conduct herself and so forth. She complained that she had been so slow and stupid in altering herself in accordance with these advices and criticisms and had even felt some resistance to changing her dressmaker in favour of that of her sister-in-law. I later asked if her husband had ever been previously engaged to be married. She said he had been—on three occasions, but each time the lady had proved unsuitable before the wedding day—it seemed after the husband's sister had expressed various opinions about her. This unmarried sister had been keeping house for the husband up to the time of his eventual marriage.

As the material accumulated it became increasingly clear to me that the husband's sister was losing no opportunity, by means of subtle criticism and "psychotherapeutic" influences, to poison the husband's mind against every woman that threatened to displace her. The newly-wed wife was, of course, the target for this augmented campaign. Pointing out to the patient that (1) the husband had found her worth marrying in the first place before

she had had any "schooling", and (2) that there had been no hint of schooling until the sister heard of the engagement, I was able to suggest that the main factors in the current disturbance were not her, the patient's, stupidity or unreasonableness, but merely the repressed conflict arising in her mind through trying to cope with hostility of which the beloved husband was being made the unwitting instrument. I said to her: "*Your sister-in-law consciously, or unconsciously, wants to kill you for taking 'her man'. None of her criticisms, for it is her criticisms and those alone which you hear from the mouth of your husband, are valid, it is not your 'improvement' but, unconsciously, your death which she is after and to which you are trying to conform! She has not yet pushed you under the ground, but she has pushed your natural emotional response to your husband under the suffocating pall of conflict and hate, that is why you cannot achieve orgasm in your sexual relationship with him. Stop trying to adapt yourself to his schooling. Let him appreciate, as he did before marriage, that your own qualities were quite good enough for him to ask you to marry him—were good enough for him then, and are good enough for him now. Whenever he offers criticism recognise that it is his sister's voice speaking and laugh, inwardly at least, at it.*"

The patient wiped away her tears and laughed then and there. "What a fool I was not to see it before." The next day she told me that she had had her first completely satisfactory intercourse, with full orgasm, since their marriage some months ago.

This example is given simply to show that there are occasions, however rare, when superficial treatment can achieve some therapeutic results. But it would be a mistake to consider that this is all that will prove to be necessary.

2. METHODS DIRECTED SPECIFICALLY AT EMOTIONAL LEVELS

(a) "*Mesmerism*": These methods, however much they lay at the basis of the witch-doctors' successes and however much they may form the basis of much psychotherapy in primitive races today, received their first impetus in the civilised world with the advent of Franz Anton Mesmer, nearly two centuries ago. With his patients in a darkened room grouped around a mysterious barrel full of rubbish, hopefully placing the metal rods that projected from it on the supposedly diseased parts of their bodies, Mesmer in a lilac dressing-gown would enter to the strains of slow music, fix his eye on each in turn and touch him with the

iron wand he carried in his hand. No doubt the drama of the situation eludes description, for many patients would fall into an hysterical attack on the spot. Thereby they were supposed to receive benefit or cure. The theory of the mechanism was as nonsensical as the proceedings. Results were said to be due to a magnetic fluid, the same as that which was supposed to flow from the planets and affect the human body. The practice, its results and the theories vouchsafed for it, all provide interesting material for the application of psycho-analytical theory—including, perhaps, the theory of the nature of the hysterical fit as an orgasmic equivalent providing comparable relief of tension.

(b) *Hypnotism*: However much we may ridicule the whole absurd proceeding and its absurd rationalisation, Mesmer certainly called attention to something. This something was subsequently developed by Braid of Manchester and others in the form of hypnotism, to which may be coupled hypnotic suggestion and suggestion. It seems to me that the deliberate use of such methods when treating intelligent persons might well lead to the suspicion in the patient's mind that the therapist is a quack and a charlatan. The procedure is so much at variance with any sensible relationship. Nevertheless, there are still some psychotherapists who have resource to this remarkably primitive procedure, and I would not deny that it may have its uses in special cases. The details of the technique vary from one hypnotist to another, and have no special intrinsic value. One, for instance, has a headlight above the head of the couch and holds an ophthalmoscope mirror a few inches from the patient's eyes and slightly above the plane of vision, making the patient fix his eyes upon it and thus maintaining a condition of eye-strain, before he proceeds with his suggestion of sleep. Schilder, for some reason or another, uses a key in a similar position, telling the patient he will get tired and sleep—as indeed who would not when such continuous strain is demanded of him! Other hypnotists emphasise regularity of breathing, even ordering the patient when to breathe in, when to hold it and when to breathe out; and when a condition of hyperventilation (itself conducive to heightened suggestibility) is established, proceed to their suggestions of rest, relaxation, inertness of succeeding parts of the limbs and body, and finally sleep. All emphasise that the important matter is not getting the patient into a light or deep state of hypnotism, but, of course, how you use the situation,

when you have got him there, for the purpose of suggesting the disappearance of symptoms and the substitutions of desired activities. In this connection I am reminded of the humorous story told by a leading physician who apparently found it necessary to offer the apologetic explanation that the patient was due to leave for Scotland within a couple of weeks and therefore it would not have been possible to attempt any other form of treatment for her main symptom of constipation. A week after her departure he received a cryptic telegram: "Eight o'clock is so inconvenient, can you please make it seven?"

It is sometimes said that, in endeavouring to get the patient hypnotised and subject to suggestion, one may adopt one of two alternative psychological relationships with him. The first is the rôle of an authoritative figure dominating the situation and giving him orders; the second is that of a kind, benevolent person coaxing him into relinquishing every form of resistance and complying sympathetically with one's wishes. One attitude is said to work better with some patients and one with others. I should imagine that the prior discovery as to whether the patient had a fixation to an authoritative father-figure, or, shall we say a fixation to a gentle, sympathetic mother-figure, might be of use in helping the physician to decide which attitude to adopt. I think on reflection it is more likely that the only attitude possible for a particular hypnotist to adopt will be one in keeping with his own character rather than one that has any reference to the needs of the patient.

In favour of those who use hypnotism as a therapeutic weapon it should be said that they mostly agree that a physician should not rush into it, but should first gain some insight not only into the patient's character, but into the psychopathology of his symptoms before finally attempting hypnotism for the purpose of obtaining a closer contact with the emotional sources of his symptoms and thereupon influencing them in the full light of one's knowledge. It seems to me that it may be rather difficult to switch over from one of these processes to the other. If one is obtaining insight into the source of symptoms through analysis, the patient is, simultaneously, obtaining at least some of this insight; and surely the tendency would be to increase this process, perhaps never fully complete, rather than to break off a "winning game" in order to try the very doubtful efficacy of the hypnotic procedure which may prevent one from reverting,

in the event of its failure, to a resumption of analytical technique.

One is certainly in close agreement with all hypnotists who suggest the process should never be used for showmanship purposes and that one should not prolong a deep hypnosis beyond the therapeutic need of the patient. Apart from the practical disadvantages that relatively few persons are really hypnotisable—I have commonly had patients who have told me that their previous psychotherapist thought he had hypnotised them, though they were never so alert in their lives but did not like to disappoint him!—there is considerable evidence that subjection to hypnosis tends to increase the dissociation of the mind, particularly of its intellectual and emotional levels, this psychological condition being the favourable soil responsible for the growth of the neurosis. Analytical methods, on the other hand, tend to integrate dissociated elements in the personality, and tend therefore to exclude favourable conditions for psycho-neurotic phenomena. The large number of cases of multiple personalities, as described by Morton Prince, are not found by analysts, and the inference is that they were artefacts created by hypnotic methods.

In order to increase the hypnotisability and suggestibility of resistant persons some psychotherapists have tried the adjuvant of sedatives, such as medicinal, in doses exceeding ten grains, sodium amyntal three to six grains, paraldehyde one or two drams, and, in recent years, even pentothal sodium and similar drugs, as described in the chapter on physical treatment under narco-analysis. This certainly facilitates the physician's task of achieving a variable degree of narcosis in the patient, but it may not always help him in the essential element of the situation, namely the maintenance of contact between the physician and the patient throughout the process.

A supposedly good method of clearing up symptoms under hypnosis is that of clearly formulating to the patient the psychopathology of his symptoms and suggesting to him that on the basis of this insight they will disappear. This, of course, assumes that the physician has already learnt the specific psychopathology in the patient's case himself.

(c) *Suggestion:* Suggestion without hypnosis has a great deal more than is recognised to do with the beneficial effects of the medicines which the general practitioner prescribes, and is naturally more likely to be effective if the practitioner himself

believes in the efficacy of the drug. The process is a psychological one however unsuspected by both parties, and is dependent upon the degree of *rappor*t between the two, specifically upon the degree of positive transference which the patient has towards that practitioner at that particular time. I have known instances occurring in a hospital out-patient department where medicine given by a patient's regular physician was most beneficial, but when prescribed by a disliked deputy the same medicine had the most disastrous effects! Similarly with a great deal of physiotherapy, electrical treatments and massage. Analytical interpretation would be that so long as it is "love" in any form which the patient is receiving and accepting he will probably derive some benefit from it.

In contrast to this we have the suggestive methods which use pain or "punishment", rather than love, to threaten or force the patient to "mend his ways". Amongst such may be included the Faradic electric brush, so commonly used in hospital practice for such things as hysterical paralyses or anaesthesias of limbs. The patient gives up his symptoms when the pain of the current is worse than the situation which caused the paralysis. Obviously, these are very crude if not positively cruel methods. The patient's problem is left unsolved if not augmented, however successfully the problems of those around him may have been solved by the process.

To call attention to the fact that psychoneuroses have causes which should be sought and remedied in order to achieve real instead of merely apparent benefit, and that a consideration of this fact is so remote from ordinary hospital practice, particularly on the surgical side, I will mention an instance that occurred on a visit of mine to an out-patient department. Oblivious to the psychological implications, the eminent surgeon was conducting a physical examination, including a pelvic examination, upon a gratified female patient, in the close proximity of medical students of both sexes. It was obvious to every person present, excepting the patient, that there was no physical basis for her pseudo-appendicitis. Therefore I was rather surprised to hear him announce that she would be admitted for operation. I eagerly awaited the explanation, which was forthcoming once the patient had departed. He said: "The operation will be a scar with the electro-cautery along the appendix region, a bandage and a week's rest."

In psychological practice one sees many instances of such "psychotherapy" by surgeons, including many where the operation has been a reality and not a sham. Cure is never effected by such means. The symptoms always return, if they ever went, usually with augmented violence. Commonly the patient is readmitted on successive occasions for operations for alleged adhesions . . . and more adhesions. Psychologically the effect of such treatment, apart from unconscious temporary libidinal satisfactions—which seem to create an addiction for their repetition—is to confirm in the patient's mind the erroneous thinking, unconscious and conscious, which led her to substitute a physical pain and disability for an unsolved emotional conflict. The really therapeutic insight into its causation, augmentation and maintenance, the insight which alone would offer the possibility of solution, is avoided by patient and doctor alike. If the surgeon himself had more insight he would be less inclined to aid and abet the malady by indulging in the temporary gratification of so perverse and displaced a perversion.

(d) *Auto-suggestion:* Perhaps we should not leave suggestion without reference to auto-suggestion with which the name of Coué is especially associated. Those who met this enthusiastic little man, who seemed to put every ounce of his libido into his convictions and his efforts to carry them over, may better understand the modicum of success he, and perhaps he alone, achieved by his methods. Further, being a thorough-going extravert, perhaps like Mesmer, he was able to carry them out to the best advantage in an intensely emotional atmosphere augmented by the presence of a multitude of hysterical disciples. The novice was ordered to intertwine his fingers and to say to himself that he could not loosen them. Eventually he found that while he was saying this he could not in fact loosen them. My own impression, watching this display with a host of spotlights focused upon the victim in the centre of a crowded Albert Hall, during an interlude of an overpowering brass band, was that the poor wretch dare not loosen them—it seemed more than his life would have been worth! However, from such auto-suggestion Coué proceeded to further experimentation by small gradations until finally he would get an hysterically lame person to walk and effectively prepare his audience for his famous formula "Every day in every way I am getting better and better". One might well ask whether the process was curing hysteria or creating it.

I have little doubt that the majority of those who lost their limp on the dais resumed it, possibly augmented, at a later date. If one knows something of the psychopathology and mechanism of such symptoms one has no doubt that they, or their equivalent, will re-erupt as surely as an undamaged seed will sprout in favourable soil, or as surely as untouched causes will produce their appropriate effects. Coué's treatment has no relationship to the sources of the symptoms or to the real life of the patient.

(e) *Faith*: In this respect it has much in common with the curative influences of faith, and like these may depend for its psychological mechanism upon the efficacy of an introjected father, omnipotent or otherwise, and the self-assurance gained by such introduction. The spiritual father (or mother) has the advantage of greater permanency than the enthusiastic or authoritative Coué, hence the auto-suggestive influence of such experiences as Lourdes, with the authority of the whole Catholic religion behind it, may be more effective. But such results are gained at the expense of insight and not, as modern psychotherapy would wish, on the basis of it. There may be an emotional gain, and that often only temporary, at the expense of an intellectual sacrifice. I am reminded of a patient of mine one of whose symptoms was self-consciousness and inability to do the public speaking which he aspired to and had idealised as a compensation for his psychosexual impotence. He arrived after having attended a terrific sermon given by the leader of a peculiar cult (which shall remain nameless). He said to me, thumping the sides of the settee with his enthusiasm while he said it, "I tell you, doctor, if I could speak like that man and sway every hearer like he did, with his power, enthusiasm and conviction, if I could believe like he believes . . . I tell you, doctor, there would be nothing whatever the matter with me. I would be cured." I said nothing in the impressive silence which followed his shouting. But after a few minutes I heard him soliloquising quietly, "*Or would that be a more serious illness?*"

In the light of our knowledge of psychopathology one may venture the opinion that indeed it would be, for psychoneurotic symptoms indicate merely an intra-psychic conflict with a relatively small impairment of the ego, whereas any delusional system, whether individual or communal, is based upon a psychotic mechanism involving the entire personality. Methods of psychotherapy which try to substitute the latter for the former,

however much they may result in some alleviation of the individual's sufferings, substitute a danger to the community, in part or in whole—witness the effects of the recent German ideology, a fair example of all that is worst in suggestion, auto-suggestion, persuasion and perhaps hypnotism.

3: APPROACH TO MORE MODERN ANALYTICAL METHODS OF PSYCHOTHERAPY

We should mention in passing the *analysis of first memories, of dreams and day-dreams, and the use of the principle of free association of thought.*

The first has, I think, been over-stressed by some schools, for, however indicative of the patient's early tendencies first memories may be to the analyst, I do not see how an interpretation of them can be of any special significance to the patient except as a very minor part of a larger process, such as that of psycho-analysis.

Dreams and day-dreams on the other hand are of inestimable value, as they reveal, in their latent content, both the current and early emotional conflicts and tendencies. Even if one's opportunity of seeing the patient and understanding his problem is going to be limited to only a few sessions it is often worth while spending at least some of them in an attempt to analyse his dream material. Dreams, or rather their latent content, have many advantages over anamnesis in that we can depend upon the truths they tell us as being really true and not rationalisations, subterfuges, delusions or untruths elaborated by the conscious levels. In the course of analytical treatment proper, whether long or short, they may, together with their association of thought, provide us with practically all the essential material for unravelling conflicts from their original inception to their current forms.

Day-dreams should be treated in the same way as ordinary dreams. The principal difference is that the secondary elaboration of day-dreams is often much greater and more outspoken. I have some evidence that the state of semi-stuporous contemplation, such as that encouraged by certain primitive religious cults, owes the possibility of its protracted maintenance to a preoccupation with unconscious erotic phantasy. The gratification commonly achieved in day-dreams is often modifications, substitutions or sublimations of ungratified instinctual needs.

An insight into them by the patient may help to show him not only why they occur, but also what primitive and sublimated needs he has omitted to provide for in his present-day life (cf. the day-dreaming of the childish type of young woman described in the chapter on schizophrenia).

Free association of thought, besides being the essential process in the conduction of almost any form of deep analysis, is also an invaluable adjunct to a psychotherapeutic interview. Often when I have not been satisfied with insight achieved at the preliminary consultation, I persuade the patient to return on another occasion and tell him that I will then require him to relax in the recumbent position on the analytical settee and to speak his thoughts aloud in accordance with the technique of free association. Frequently the material so produced throws a flood of light upon the mere formulations or clinical case-sheet material of his sitting-up interview. This method of psychological approach, which consists essentially in the subject speaking any and every thought in a relaxed state without regard for its emotional valuation, was discovered by Freud and has ever since been of the utmost value in every analytical form of investigation and therapy. It will be dealt with at some length when we come to consider the technique of Freud's method as a whole. The succeeding chapters dealing with this subject are a continuation of this third, analytical and main, division of the art of psychotherapy.

however much they may result in some alleviation of the individual's sufferings, substitute a danger to the community, in part or in whole—witness the effects of the recent German ideology, a fair example of all that is worst in suggestion, auto-suggestion, persuasion and perhaps hypnotism.

3. APPROACH TO MORE MODERN ANALYTICAL METHODS OF PSYCHOTHERAPY

We should mention in passing the *analysis of first memories, of dreams and day-dreams, and the use of the principle of free association of thought.*

The first has, I think, been over-stressed by some schools, for, however indicative of the patient's early tendencies first memories may be to the analyst, I do not see how an interpretation of them can be of any special significance to the patient except as a very minor part of a larger process, such as that of psycho-analysis.

Dreams and day-dreams on the other hand are of inestimable value, as they reveal, in their latent content, both the current and early emotional conflicts and tendencies. Even if one's opportunity of seeing the patient and understanding his problem is going to be limited to only a few sessions it is often worth while spending at least some of them in an attempt to analyse his dream material. Dreams, or rather their latent content, have many advantages over anamnesis in that we can depend upon the truths they tell us as being really true and not rationalisations, subterfuges, delusions or untruths elaborated by the conscious levels. In the course of analytical treatment proper, whether long or short, they may, together with their association of thought, provide us with practically all the essential material for unravelling conflicts from their original inception to their current forms.

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CHAPTER XXVI

PSYCHOLOGICAL METHODS OF TREATMENT: SOME INDIVIDUAL METHODS OF TREATMENT

SOME of the views of Kraepelin, Bleuler and Kretschmer have been mentioned in the chapters on schizophrenia. The views of Charcot and Janet, still so liberally quoted in psychiatric textbooks, have been superseded by Freud's discoveries, and in my opinion are now merely of historical interest and of no practical value.

Meyer: We next come to the rather eclectic system of that great psychiatrist Dr. Adolf Meyer, called by him *psychobiology* to signify the stress he lays upon his patients being physical beings with a tendency to certain *types of reaction*.

Analytical discoveries are to some extent taken over by Meyer, but are used with perhaps undue precaution as though he were afraid of disturbing the patient's emotional balance. The impression is that we stay firmly anchored to common sense for fear that if we weigh anchor we shall be all at sea without any possibility of control. However, it may be conceded that Meyer's method and action are understandable if it is psychotics that are being dealt with. For here an undue disturbance might conceivably be easier to achieve than to readjust. In fact, even psycho-analysts often prefer to use indirect methods in attempting to treat psychotic cases, particularly as one would not be aspiring to any very perfect adjustment. But if we are dealing with other than mental hospital cases, Meyer's avoidance of deep interpretation is the very thing to avoid. Otherwise we shall not hold our patient for long and shall effect only superficial treatment and little change. And rightly so, for our fear of deeper levels is indicative of unfamiliarity with them and consequent incapacity to deal with their conflicts in which lie the roots of psychogenic illness. The method is therefore beside the point in the treatment of psychoneurosis, except to render very superficial help.

Reich: A few other individual methods of psychological treat-

ment should be mentioned, amongst them the method and theory of that most brilliant and much-neglected writer, Wilhelm Reich. For some reason or other he calls his system "vegetotherapy", and perhaps the best known of his books is *The Function of the Orgasm*. It seems that he concentrates attention upon parts of the patient's body that are being held in a state of rigidity and makes the patient's first task that of relaxing these rigid regions. Further, he recommends starting with the analysis of the negative transference and resistance. This sounds like a good idea, seeing that these are the factors in the situation most likely to be ignored even by analysed psychotherapists, and most certainly by the unanalysed. But how he can start with these most difficult elements in the situation before a sufficient positive has been built up to hold the patient, I find it difficult to conceive. Indeed, from reading his books it is not at all easy to discover the details of the technique in part or as a whole. His theories are far easier to understand, particularly his most emphatically held theory that orgasm is the essence of all sexuality and that degrees of what he calls "orgastic potency" have infinite gradations no matter what degree of potency may exist in the ordinary sense. I think many analysts would agree that there is some correlation between the degree of full psychosexual expression in orgasm and the presence and severity of neurotic symptoms. Indeed, experience teaches us that there may be some justification for holding that there is only one neurosis or psychoneurosis and that that is some degree of psychosexual impotence—or perhaps as Reich would have it, orgastic impotence—for it is quite rare to find a patient whose psychosexual or orgastic potency proves on deep investigation to be entirely satisfactory and one hundred per cent. So rare is this that if one does hear of such a patient at a first interview, one almost instinctively forms the mental reservation that in the course of analysis there will be found to be something wrong with his claim. In my experience this always proves to be the case, though unlike Reich I would stress that the psychological elements as a whole must be accepted as an essential ingredient in the criterion. That is why orgasm, however complete it may be on a physical plane, if it fails to be an adequate psychical expression of an adequate emotional relationship of the parties, does not denote full psychosexual orgastic potency. Like any other act, the sexual act (like its counterpart, abstinence) to be

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psychologically satisfactory must be an expression of the individual as a whole, physical and mental, at that time, and probably, like other acts, subject to the natural variations of his personality as a whole. It may not be natural always to be the same, or at the top of one's form, either mentally, physically or sexually.

Reich's writings are provocative of enthusiastic agreement; but I have noticed that this faculty is most marked when he is talking about aspects of the subject with which one is not oneself very familiar. I thought his physics was marvellous, though I doubted his psychotherapy; but when I read his arguments to a physicist friend *he* thought that his psychotherapy was marvellous but his physics, such as his Bion theory, almost incredible. It is perhaps a pity that his fluency and enthusiasm may exceed his justification in all respects, for I am sure that some of the special points to which he has called attention, including the psycho-physical importance of orgasm, are valuable contributions. This last in particular just needed the emphasis which he so masterfully places upon it. It had too long been neglected despite clinical evidence of its importance. Future psychologists will, I hope, benefit by the attention which he has rightly focused on this subject. The function of the orgasm should no longer, as he complains, be treated as the Cinderella of the sciences. Borrowing his style: I hope that one day his Cinderella may find her prince—and I am not referring to Morton Prince, but to the prince of modern psychology, namely, to psycho-analysis—with the result not only of a perfect union with full orgastic potency, but with the birth of the perfect child of psychotherapeutic evolution, the fructification of centuries of clinical psychological endeavour!

Schilder: Another modern development of psycho-analysis, though very different from the above, is that of Schilder's *Group Psychotherapy*. I can hardly hope to do it anything like justice in a short summary, particularly as it strikes me as the antithesis of a method (psycho-analysis) which depends so much on secrecy and confidence for its success. In this connection we should remember that Schilder insists that the group method is begun only after several private sessions and only after a preliminary insight has been reached. Even then the patient goes through a preliminary period when he writes down his biography in extraordinary detail. His instructions for this transcription

are that he must hold nothing back, he should in fact, in writing his biography, exercise at the same time the freedom and license of free association of thought, erasing nothing even if he later contradicts it, and certainly not aiming at any sort of perfection. He should write down every memory pertaining to early childhood, especially before the age of five, and this should include any memory he can conjure up of infantile interests in food or excreta. His sexual experiences in early childhood must also be given in full detail, including opinions and theories which he then held. This process must be followed through the school age to puberty and must bring in persons who played a part in his life. He should show development of his aims and interests, any perversions, experiences, thoughts and so on, however much they may not conform to his previous moral standards. Phantasies, dreams and wishes must also be recorded. No detail should be regarded as unimportant.

One can readily agree with Schilder that the progress of the patient's psychotherapy may be much helped by this necessity of letting his whole life pass before his eyes. I may confess that I myself have tried the same subterfuge, without the programme of proceeding to group treatment, when I have found it impracticable to see sufficiently often a patient who appeared to want to tell me all this. How much transference (the main therapeutic asset in all forms of psychotherapy, whether acknowledged or not) comes the way of the absent analyst during this process of biography-writing and how much eludes the analytical situation is quite problematical. A further problem would, of course, be how much essential material may never emerge, as the patient obviously has a free hand to indulge in whatever resistances and defences he pleases, consciously or unconsciously, in accordance with the particular build-up of his character and as an expression of the balance between these already-formed associations of thought and resistances to them. In other words, we may depend upon a biography, but not upon an analysis.

However, according to Schilder's group method the process does not, of course, stop there. As Schilder says, every part of his life history will need an interpretation in the course of further treatment. It is only after he has reached a preliminary orientation that he is seen together with a group of other patients who are in various stages of the treatment. The groups commonly consist of two, three or more people up to six or seven. Often

they are selected on account of similarity of underlying mechanisms.

One can well believe Schilder when he says that in some cases the resentment at being taken before others is not immediately overcome! Certainly one good thing about the method is that the patient is allowed to be a silent participant until such time as he feels like talking. Further, every patient who participates in groups is also seen individually two or three times a week. The same principle of freedom of thought and speech as exists in the private interview is encouraged, with the result, says Schilder, that when one got a negative-transference group criticising the process or the physician and saying, for instance, that he is not sufficiently interested in them individually, but rather in the scientific problems and so on, the patients with positive transference felt the need to defend the analyst against the others.

One of the advantages, it is held, is that the individual sees the fundamental identity of his problem with the problems of others, and that this takes him out of the isolation into which his neurosis has led him. The physician is not supposed to stand aloof, but to claim an equality with each member of the group, although complete freedom of association on his part is neither expected nor desired. This seems to me a peculiar form of cant. I think similarly of Schilder's objection to mixing the sexes in the group, for what he calls "obvious reasons". Finally, even he admits "It is unquestionable that in many cases, perhaps even in the majority of cases, individual psycho-analysis may be the more efficient method".

This form of therapy reminds us of a children's classroom where a frank exposure of each and every child's character to one another, to the teacher and by the teacher, is the order of the day. Perhaps it reminds us especially of an ultra-modern type of school where stress is laid on free individual self-expression and perhaps an absence of discipline—but in Schilder's class not to the extent of co-education. Evidently the order of the day in group therapy is that one's instinct urges and primitive conflicts as well as one's sublimations are freely revealed and discussed. If these as one might expect for "obvious reasons" tend to be put into practice by the participants of the group in private, outside of their regular meetings, Schilder has ensured that they will be homosexual rather than heterosexual.

I would not insist that this would necessarily be psychologically less desirable than masturbation in solitude. I am quite willing to admit that, even on the sexual plane, group relationships or relationships *d deux* may have their advantages. I am reminded of the rather bright and very sociable little schoolboy of fourteen sent to me by the head master of a public school on a "very serious charge". The question appeared to be whether to expel or not. There was nothing wrong with the lad except his perhaps unusually healthy degree of extraversion and sociability. I said to him: "As you know, the other boys masturbate secretly, are not found out, and nothing happens. You have been trying to make it a social affair, and that the school will not tolerate. So I am afraid you will have to be as bad and secretive (and as introverted) as your less-favoured companions, until such times as you can make it a heterosexual process, as then only will society permit you sexual expression in anything but an introverted manner." Of course this took a little explaining, but the relationship between a socialised activity on an instinct level and that of socialised analysis, in the form of group psychotherapy, is obvious, and who am I to say that extraversion has not advantages over introversion?

Nevertheless Schilder's group psychotherapy gives the impression of being the particular "bee" which has urged him to write so enthusiastic a book. Perhaps it is always a "bee" that prompts us to do any energetic proselytising, be it that of forcing our will on others, as Francos, Mussolinis or Hitlers, or of striving for the bloodless victories of the pen. Therefore, when you read Dr. Schilder do not be uncritical of his long exposition of group psychotherapy. There must be something in it. There must be some tendency to obtain relief by giving and by hearing confession in groups; otherwise what explanation could there be for the Oxford Group Movement (Buchmanism) epidemic. Nevertheless experience of the analysis of neurotics shows us that the vast majority are abnormally shy and sensitive people for whom revelations that were any deeper than harmless superficialities, before a group of "brothers and sisters", would be anathema. Furthermore, I should imagine that the long lists of horrible questions Dr. Schilder proposes in group discussions would at the best mobilise strong resistances in his patients, or worse still might be near enough the bone to produce positive illness. They might better be listed as what one should tactfully

avoid in group discussion. In fairness, however, it should be said that Dr. Schilder stresses that the physician should bear in mind that these questionnaires can be understood only by the experienced, that they are merely a guide for the physician, who should give them in the form which is appropriate to the patient and the degree of his insight.

How patiently and kindly must the clinical psychotherapist wait before his patient reaches that mature stage of analysis when the strongly resisted subjects listed by Dr. Schilder are spontaneously broached by the patient, and the nucleus of his neurosis is reached! If, on the other hand, group relationships are left to find their natural level, that level will probably be on the conscious or sublimated plane of the ideologies. In that case we may find Dr. Schilder's psychotherapy group degenerating into the equivalent of the modern House of Commons—though fortunately, in this instance, without the comparable power to put their unresolved conflicts into practical operation to the destruction of humanity.

Adler: Another individual method is that actually called *Individual Psychology* and introduced under that name by its originator, Alfred Adler. It stresses the individual's *ambitions*, *aims*, *what he is striving for*, and the general plan of his life towards that end. It stresses *inferiority feelings* which it alleges are based upon the inferiority of some organ or aptitude or ineptitude of the individual. It stresses that the individual tries to deal with these inferiorities by the method of *over-compensation*, particularly in the realm of phantasy, by bolstering himself up with feelings of *superiority*, and perhaps refraining from any practical attempt at coping with the world of reality around him.

The *will for power* appears to be the driving force behind a lot of the activities of life. Psychotherapy aims at exposing to the patient where he has gone wrong, persuading him no longer to be driven by his feelings of inferiority and compensatory superiorities, and instead to subordinate himself to the community spirit. In other respects there is a good deal in Adler's system, which is related to the analytical way of interpreting. Extra stress, however, is placed upon *first memories* in addition to infantile situations. The whole subject is kept on a very much more superficial level than that of psycho-analysis, and simplification or over-simplification is its characteristic.

But perhaps the most striking difference is the almost complete

neglect of sexuality, in any and every form, as having any bearing whatsoever upon the problem. In the light of one's experiences of the material produced under free association by practically all patients, this may immediately cause one to suspect resistance symptomatology within the Adlerian system itself. The only "organ inferiority" that I have noted was consistently stressed, sooner or later, by every patient, both in free association and in dreams (whether such organ were symbolically represented as deficient hair, limbs, teeth, eyes, clothes or what-not), invariably turned out to be none other than a symbol or substitute for the sex organ, implying an obvious symbol for feelings of sexual inadequacy or impotence. Psycho-analysis shows, perhaps to our astonishment, that feelings of inadequacy at this level tend to permeate all levels of the individual's self-expression, including sublimations, and are rarely adequately compensated for. Adler is evidently stressing the symbol—and that well removed from genital identification—rather than what it symbolises.

Of what is *this* a symptom? Adler himself told me over a cup of coffee at a club in London. He said: "I never did see eye to eye with Freud and his *libido* theories throughout all the years of our association, and then when he published his *Drei Abhandlungen zur Sexualtheorie* (in 1905) it was too much. I left him!"

Nevertheless a rigid resistance can denote as strong a character or personality as an intense enthusiasm, and this ardent, pyknic little man, with his sallow complexion, rather large head and face, rimless pince-nez, lively eyes, perfect self-composure and complete extraversion, was as much at home before a large audience, answering their questions with full psychological freedom of superficial interpretation, as he would have been with a single patient in his consulting-room. However limited were his theories and his total absence of such insight as is perhaps only vouchsafed to the introvert, he was a living, albeit innocent, example of the fact that psychotherapy depends on transference, for his success with audiences was clearly dependent upon his powerful, sympathetic personality and his faculty for gaining immediate transference from large and small audiences alike—facilitated no doubt by the fact that he had one very important attribute in common with the unanalysed: repression of sexuality and hatred of the "*Sexualtheorie*".

Jung: The *Analytical Psychology* of Jung is also difficult to describe adequately in the small space at our disposal. Perhaps

his first move in the direction of dissociation from Freud consisted in his "de-sexualising" of the *libido* by the simple method of saying that all life's urges were libido, and suggesting the use of the term "life-urge" as synonymous with it. In fact, it was when on his American tour that he wrote to Freud exhilarated that he had found, as he said, a method of making psycho-analysis acceptable even to American audiences, apparently by this simple device. Freud's reply was not encouraging. It was to the effect that any popularity gained at the expense of truth did not seem to him commendable. However that may be, Jung moved rather in the direction of popular psychology than in that of Freud's psycho-analytical progress. It brought him into what I feel is a wilderness of folklore and mythology ever moving further and further from the fundamentally simple, primitive instincts. Apparently this is the *natural* direction of libidinal development or evolution, otherwise how should mythology and folklore have come into being during the course of evolution? But it does not seem to me to be the direction of an *investigation* into the basic cause or roots of more complicated structures, whether symptoms or sublimations, which arise and whose origin analytical science would wish to investigate. On a mental plane, though of course not on a physical, the popular direction of thought is "sex-fugel", and the Jungian direction is similarly "sex-fugel", and they are therefore in *rappoport* with each other; they may shake hands on it and together understand more and more of the symbolic presentation of the meaning of life, its myths, legends and ideologies, even to the concept of the creative force of the unconscious, but at the same time they are rising further and further from an appreciation of the fundamentals. It required a movement in the opposite direction, towards sex rather than away from it, a movement initiated, not by popular or individual preference, but solely and simply by the clinical material produced in the course of analytical investigation through free association of thought and dream associations by patients themselves. It was through this investigation that the simple and primitive *source* of symptoms and sublimations and the relationship of cause to effect was understood as clearly as the relationship of physical life to its original oosperm.

Jung's over-explaining and elaborating elaborations are reminiscent of the paraphernalia of culture which heaps more and more gratifying complications to hide the comparative simplicity

of the original animal within. Nevertheless there is no denying that there is much not only of interest but of good and useful value in these synthetic products, and in some of the abstractions and groupings of them. For instance, Jung's doctrine of *extraversion* and *introversion* has come to stay, and I think has some value in all psychiatric and psychological work. His *archetypes*, though unclassified, help to show the relationship or primitive cultural forms to one another and to their modern equivalents. The *collective unconscious* is, I think, also an interesting conception and natural deduction. The concept of the *creative force of the unconscious* may be a useful reminder that reductive analysis shows us only the more and more primitive phases, and causes us to ignore the possible directions of progress and evolution. But I doubt whether it has much practical utility apart from this. The *word-association test* is like building a child's game with analytical toys, and in spite of some popularity and some experimental value is quite useless as a weapon in the analytical armoury.

Another of his concepts worthy of mention is that of the "*persona*" signifying the face-mask or personality that one presents for social purposes whilst at the same time one is hiding, largely from oneself also, those opposite tendencies which would not be socially acceptable in one. This phenomenon is specifically stressed in the concurrent display or expression of those psychological tendencies which correspond to one's physical form as male or female, with a corresponding repression of those psychological tendencies which if exposed might brand one as homosexual and therefore be out of keeping with the "*persona*". Thus it would seem that males are going about presenting masculinity and hiding female tendencies ("*anima*") and women are going about displaying feminine personality, their "*persona*", whilst they are hiding their psychological masculinity ("*animus*"). A few psychotherapists have constructed a whole system of theory and treatment based upon this somewhat incomplete conception. But of all the concepts and terms invented by Jung that of "*complex*" is easily the most important both in his system and in that of psycho-analysis, which has permanently adopted it.

There is one respect, and an important one, in which Jung's system deserves adverse criticism, that is that it helps patient and analyst alike to accompany each other in a continual flight

away from the fundamental meaning and origin of the illness, substituting on the way rather pleasing, artistic creations in lieu of a proper appreciation of reality—and reality cannot be escaped indefinitely, unless it be by an ultimate flight into psychosis and death. Unless an artist, however artistic, has at least some adequate appreciation of reality he will die of poverty, inanition or tuberculosis; and his artistic mode of escape from unwelcome realities will be brought to a full stop by those same unwelcome realities.

CHAPTER XXVII

PSYCHOLOGICAL METHODS OF TREATMENT: PSYCHO-ANALYSIS (GENERAL PRINCIPLES OF TECHNIQUE)

We now come to the more serious and constructive aspects of this work. We have passed in review a succession of psychological implements, techniques and systems.

It is only natural that those who are totally ignorant of the aetiology of nervous symptoms should first attempt the most direct and superficial methods of eradicating them, such methods as we reviewed in Chapters XXV and XXVI: trying to get the sufferer to see the error of his ways (which in most cases he has already seen only too clearly, without effect), to bring his reason or intelligence to bear upon his symptomatic manifestations, to use his will-power to control them, to pull himself together, etc. Experience teaches us that such processes, directed as they are against the conscious levels of the mind, merely increase the strain which the patient is already enduring and produce no lasting beneficial effect. As a general rule they are useless in practically all nervous illness.

With further knowledge and insight we will discover that this is because symptomatic behaviour, human behaviour in general, life and reproduction, all really emanate from deeper, unconscious levels of the human psyche. Therefore, to make any effective alteration in these manifestations we must not be misled into mistaking the manifestations for the disease, still less for its source, and thinking that they can be magically dispelled without even seeking this source from which they spring. We would not try to stop the steam from a boiling kettle by sealing the spout and lid without regard for the water within or the burning gas-jet beneath. It is almost as inconsistent with our knowledge of aetiology to try to cure neuroses by methods directed at the conscious levels of the mind. In so far as the use of such methods has in certain instances appeared to have some modicum of success, psychopathology teaches us that this result has been achieved, not by the actual method used or in the way supposed,

but by some factor which eluded our observation. This factor is always an emotional one and consists invariably of emotional transference relationship, however undetected by both parties, between the patient and the physician. Psycho-analysis may show that in some instances it consists of nothing else than an unconscious introjection of a good figure with consequent gain in super-ego strength, emotional direction, feelings of security and confidence. It is as though the sufferer had introjected some supporting potency, as the child does from its parents—in lieu of his own deficiency.

In short, whatever psychological treatment is to be successful it must be relevant to the aetiology of the illness. The systems of psychological treatment which we have reviewed are more or less insistent in tracing, to some degree and to some depth, the early roots of the illness, and recognise that its present form is merely the latest eruption from these deeper levels. They have one and all borrowed something—some of them almost everything—from Freud's discoveries of psycho-analysis. But they have mostly not been one hundred per cent. convinced, and have tried to combine psycho-analytical discovery with an admixture of the more superficial points of view that would lead them to tackle symptoms from their surface levels. In other words, they have watered down the "incredible" revelation of psycho-analysis either with subjective incredulities or with what some would call the more acceptable inclusion of common sense. I wonder what the physicist would say if the common-sense merchant tried to apply the conclusions of his everyday experience to the revelations of such discoveries as led to the atomic and electron theories and to relativity. The position of psychotherapy as a whole, if by that term we may embrace all forms of its application and all theoretical systems, is in some such muddle as results from the admixture of scientific learning, superficial observation and subjective approaches. It is, I think, clear to us that so far, in spite of all the attempts of extra-analytical psychologists, Freud's psycho-analysis remains the deepest and most scientific of all the systems.

It is not easy to define its special characteristics, nor to describe its technique and theory in detail, but the attempt will be made in this order.

All analytical methods deal specially with the *unconscious mind*, but, if we would define the special characteristic of psycho-

analysis in particular in one word, it may be best to say that it is a method which deals systematically with *resistance*. A few definitions will be necessary to explain even this simple concept. Having discovered that patients' symptoms, the things of which they complain are incomprehensible to them, that they do not know *why* they suffer from this or that disability or compulsion, that they are in short *unconscious* of the *source* of these phenomena, just as unconscious as they are of the source of their dream material, Freud postulated the theory of the unconscious mind. There are, of course, many other evidences to justify this conception, such for instance as post-hypnotic phenomena, and indeed practically everything that emerges from amnesia during a course of psycho-analysis. Freud discovered not only that the source of all psychoneurotic symptoms lay in this unconscious mind, but he also discovered the presence of certain phenomena which prevented him from reaching these sources, which seemed to prevent the patient from being, or from becoming, conscious of them. Further attempts to reach these sources, the mainspring of the symptoms, were met by a great deal of opposition on the part of the patient. In spite of the patient having the best will in the world to be helpful, this opposition nevertheless appeared to operate. Occasionally conscious opposition came into the picture, but that was not so interesting as the evident fact that the principal opposition was largely unconscious. These obstacles to the progress of analytical discovery Freud termed "resistances" and the general phenomenon of this opposition was termed "resistance". It is the business of psycho-analysis to deal with resistance and to remove it, for only by this means can the source of the neurosis be revealed.

In the course of this struggle with resistance another curious phenomenon came to light, and that was that instead of the patient through his free association of thought continuing to reveal more and more of the origins of his symptoms and the conflicts from which they arose, together with the childhood memories connected with their chronological development, he developed instead a certain contentment to be in the analyst's presence, or a complex state of emotions, positive and negative, in relation to the analyst, and his mental energy simply ceased to flow into the deeper memories of his past. He was concerned less and less with that, and more and more with the present, most particularly with the present moment of his session in the

analytical room with the analyst. Thus the process of analysis had come to a curious and unexpected end. Freud's genius soon discovered the meaning of this extraordinary phenomenon. It was that the patient was actually *re-living* his past emotional life of an early age, indeed of infancy, just as he had lived and experienced it with his parents or their surrogates. He was living it with the analyst according to the identical emotional pattern, and was unaware that he was doing this, unaware of the explanation of this phenomenon, or indeed that there was anything to be explained.

As "resistance" has been defined as everything which interferes with the smooth progress of analysis, this surely was resistance indeed. In psycho-analysis it is known as the phenomenon of the *transference*. Thus it was discovered that though the business of analysis was that of dealing specifically with resistances and attempting to remove them, the magnitude, strength and difficulties connected with this special instance of resistance, namely the transference, was so great and so difficult to remove, that the distinctive feature of psycho-analysis became not so much the removal of resistances in general, but the struggle with this special form of resistance and the technique of dealing with it. Naturally this proved to be no idle occupation, for not only were the phenomena of the transference shown to be nothing more or less than a re-living of the infantile emotional patterns which lay at the root of the neurosis, but the interpretation and resolution of them yielded immediate fruit in the form of bringing back to the patient's memory forgotten incidents, objective and subjective, belonging to the period of infantile amnesia—that early period of life which there is otherwise no possibility of recalling in any detail. Moreover, it was shown that it is during this very period of life that the principal emotional struggle of every individual's history takes place—a struggle which makes or mars him not only for his social relationships thereafter, but for his intra-psychic emotional balance and well-being. This principal struggle was shown by analysis to have to do with the child's relationship to parents, or parent surrogates, the frustrations which arose to his omnipotent libidinal wishes, the mixture of hate as well as love which was thereby stimulated within him, the fears engendered on account of his sexual and aggressive desires, and in general an impossible state of conflict which he finally "dealt with" by the method of repression,

thereby largely abandoning, or rather repressing the primitive form of his libidinal life. This constellation of desires and fears, loves and hates, when repressed is known in psycho-analytical terminology as the "*Oedipus Complex*".

One of the theories of psycho-analysis is that every neurosis has its nucleus within the Oedipus complex (though it may have threads running back to even earlier fixation points) and that any form of psychotherapy which fails to reveal and resolve the Oedipus complex fails to reach the essential source of the illness and therefore at best can achieve only partial and temporary alleviation.

At the same time psycho-analysis, being the system above all others which deals with the phenomenon of resistance, especially with the phenomenon of the transference, and perhaps being the *only* system which deals *adequately* with this latter phenomenon, is held to be the only method which can hope to reach and remedy the nucleus of any psychoneurosis.

Technique: It has elaborated a very precise and rather rigid technique for the purpose of achieving its ends, and it is now time that I tried to describe this technique in some little detail. First it may be said that I can hope only to describe it, not to teach any reader how to use it, for the technique of psycho-analysis can only be learnt by an adequate personal analysis. The reason for this may become clear later, but one may say at this point that it is due to complexes and resistances, and tendencies to counter transference, in the analyst himself which will make it impossible for him to put this technique into successful practice unless he has first been subjected to it and obtained *insight into his own resistances and unconscious tendencies*. The resistance, or bandage that covers the eyes of the mind and prevents it from seeing into its own unconscious, must be removed before it can see clearly into the unconscious mind of other resistant or "blind" people. Otherwise the situation will be a case of the blind leading the blind. The following is therefore merely a description of technique and not an instruction for practical application.

The present position might be best understood in its proper perspective by a chronological review of its past and present development, but space will not allow me to devote more than a few words to this.

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some cases of hysteria through the use of hypnosis, but soon found disadvantages in the hypnotic method, one being that relatively few patients were hypnotisable. Particularly, he discovered that the resistances (to remove which hypnotism had been utilised)—resistances to memories of traumatic events which had precipitated, if not caused, the neurosis—he discovered that these resistances could be removed by an alternative process without invoking the aid of hypnosis. This process was the very simple one of encouraging the patient to do free association of thought. Thereupon Freud found he could observe the points at which resistance arose and immediately obtain some insight, not necessarily into the causes of the illness, but into the nature and causes of the resistance. This frequently enabled him to remove the immediate resistance, whereupon the association of thought would continue, finally leading to considerable insight not only into the unconscious resistance, but into the nature of the unconscious material that was being resisted.

It was only natural that the analyst would reveal to the patient what he had himself seen. This was an early psycho-analytical method of *active interpretation*. Unfortunately, however correct and accurate these interpretations of unconscious and resisted material were, this method of procedure did not usually lead to the desired therapeutic result, and therefore psycho-analysis now regards it merely as an adjunct in a wider plan. Some systems of analytical treatment still place this primitive method, abandoned by psycho-analysis over forty years ago, in the forefront of their technique. Perhaps all psychotherapists, including psycho-analysts, use it on occasions in special cases. I myself have done so and have usually found that the more correct and accurate the interpretation of strongly resisted material at a pre-transference stage, the worse the result. Unless the patient has reached a sufficiently advanced stage of transference analysis, and unless the resistances related to his unconscious material have been sufficiently weakened, the more its revelation by interpretation tends to act as a shock, and, far from producing therapeutic benefit, merely stimulates his resistances to redoubled efforts. Moreover, he might ally all the strength of his ego with these resistances, previously and still largely unconscious, denying not only the truth of the revelation, but also denying the analysis and the analyst with it. I have seen a sample of this situation in a domestic circle where the wife,

aspiring to become an analyst, used her new knowledge to castigate her husband with sadistic interpretations.

Having presumably recognised the disadvantages of the first ready-to-hand method, the second step in the development of psycho-analytical technique was, instead of active interpretation, to allow or to encourage the patient to make his own interpretations as the time became ripe. It was a more tactful and, from the patient's point of view, a far more natural method. It had considerably less traumatic effect upon him; but again, curiously enough, although it might effect improvement and not interfere unduly with transference development, by itself it did not lead either to a complete analysis or to a complete cure. It is still of course utilised within the general scheme of the modern psycho-analytical system, but I would emphasise essentially *within* that scheme, and not as an independent system or technique of its own. Like the method of active interpretation, this later, gentler method is also placed in the forefront of their technique by some schools of psychotherapy which do not aspire, as does psycho-analysis, to a complete interpretation and resolution of the transference situation.

The reason psycho-analysis does not place interpretation in the foreground is because it is aiming at a more long-sighted policy. However clear the pathology of a case may be, it is not psycho-analysis to offer psychopathological explanations to the patient during the early interviews. It merely tends to rob him of necessary modes of relief (under which term we may include symptoms) while offering him nothing in place of them. But more serious than this: in so far as these interpretations are offered in spite of resistances, this process would certainly tend to interfere with a smooth development of transference relationship to the analyst. No child will learn to cling to his mother if a little pin is stuck in him every time. Nevertheless, resistances commonly have to be interpreted wherever they hold up analytical progress. This may seem to be a subtle distinction, but is not so difficult for the analyst if his own sadistic tendencies have previously been made conscious to him.

We may decide upon other methods than psycho-analysis, methods more appropriate to the external circumstances of the case, if not more appropriate to the psychopathological nature of the neurosis. It is not every patient who can attend five or six times a week for a more or less indefinite period. But what-

ever method we may decide upon, it is as well to have been analysed ourselves, for otherwise who knows (certainly we do not) what particular unanalysed unconscious urges of our own id, super-ego or ego we are, all unknowingly, gratifying at the expense of the patient. Whatever approximation to a full psycho-analysis we may choose, it is as well for us to know its technique as initiated and developed by Freud and his school, and the latest developments which this technique has reached.

Its chief characteristic and essential principle has been defined as that of a *strategic technique* mainly directed throughout to *transference development* and to *transference analysis*. Techniques which fall short of aiming at a full development and a full insight into, and interpretations of, transference may certainly have their uses, but they are not psycho-analysis. Psycho-analysts hold that nevertheless the beneficial effects of any of these other methods are also due to transference, and the essential difference between them and it is that, whereas other forms of psychotherapy more or less blindly use the transference to attain their end—amelioration of the patient—psycho-analysis is the only method which is not satisfied to leave any portion of the transference free from investigation, interpretation and dissolution. This, no doubt, is an important claim if we can believe that any technique, even that of psycho-analysis, succeeds completely in such an ambitious programme. Psycho-analysts will admit that a condition of positive transference, although quite blind and unanalysed, often has the effect of alleviating, if not causing the complete disappearance of, practically all the patient's symptoms. Nevertheless they say that methods of amelioration, or so-called cure, other than those of psycho-analysis are not worthy of being called a science, as they leave their main instrument and its operation undetected. They are therefore not essentially different from the psychotherapy of the general practitioner or family doctor whose patients love him because he is a kind-hearted man, and clever, and always feel better for having spent five minutes in his company and for taking his medicine, whatever it may be, three times a day until the next visit.

THE TECHNIQUE OF PSYCHO-ANALYSIS: GENERAL PRINCIPLES OF TECHNIQUE

I shall now outline the general principles of psycho-analytical technique before passing on to describe their actual application

during the course of analysis. To my mind the general principle that requires emphasis above all others, principally on account of the unanalysed being quite unable to appreciate its absolute necessity, is the principle of utter and complete and sustained *passivity*. This is as important a rule for the analyst as free association of thought is for the patient. The attitude and behaviour of the analyst is always passive. The degree of its passivity and its absolute necessity will never be sufficiently appreciated by anyone who has not himself been analysed. To begin with he will probably find silence intolerable, perhaps as intolerable as the patient may be finding it, and instead of being intellectually preoccupied with the thoughts of what the patient is feeling, why he is silent, and considering possible unconscious phantasies and resistance to them, in short the conflict which is holding up the patient's free association of thought and causing his silence, instead of thinking of these things he will instead be subject to a compulsion coming from within his own unconscious to relieve his own tension or anxiety by breaking the silence at all costs. The result will be a typical analytical opportunity missed, and, however relevant his remarks may be to the conscious situation, they will most certainly be irrelevant to the unconscious situation, the exposure of which is the essential analytical process. In other words, he will not be doing analysis at all, and perhaps circumventing the possibility of it ever being done, at least by him. Unless the analyst is himself free from anxiety, or at least has full insight into this anxiety of his, he will be quite incapable of even beginning an analysis.

Furthermore, whatever the patient says to him, unless he is capable of discounting and completely concealing his own tendencies to emotional reaction even to the mildest thought or idea, he will increase rather than remove the patient's resistances and at the very best disfigure the picture of the patient's emotional patterns, for which, especially in the form of the transference, it is his business to provide a clean slate for their unadulterated transcription. Therefore it goes without saying that there must never be any emotional display on his part, especially must he not react in the slightest particular to the emergence of any negative transference, such for instance as criticism or a home truth, ventured by the patient. But far more than this is required of him. He must, so far as possible, reveal nothing of himself, neither of his reality life, family, etc., habits,

nor of his mental life. No opinion must be ventilated, no theories must be propounded, least of all those of psycho-analysis, and furthermore there must never be the slightest hint of self-assertiveness or of dogmatism on his part.

He must know exactly what his function is and stick resolutely to that function and to that alone. Throughout the first stage of the analysis at least, he has one function and one only to perform, and that is to keep the patient's free associations of thought working. Therefore, so long as they work, so long as the patient is going ahead with free association of thought and not showing any undue or protracted resistance—and, incidentally, such resistances may be full of words as well as silence—so long as free association of thought goes on and analytical progress continues, the analyst does and says absolutely nothing, even for weeks or months. I said so long as the associations work and progress goes on. In most cases free association of thought does not work unimpeded for very long. Resistances, verbal, silent or otherwise, will soon manifest themselves, and the analyst's assistance will be required.

Resistance or defence-resistance may be defined as anything that interferes with the patient's expression of free association of thought and with the progress of analysis. How the analyst deals with it I shall endeavour to describe when we come to consider the first stage of analysis, and especially in Chapter XXX under the heading of "Defence-Resistance" (p. 387).

The second general principle of outstanding importance is the rule of *free association of thought*. It may be necessary to explain this at the outset; indeed, some analysts make a rule of spending several minutes at the beginning of the first session in describing to the patient exactly what is meant by free association of thought. They then sit back and watch the patient struggling to avoid it! Personally, I prefer to offer no explanation so long as the patient talks freely. The longer I can defer explaining the rule the better pleased I am. A patient often freely associates with less anxiety if he does not know that he is freely associating. It is less anxiety-provoking to allow the situation to assume a natural course, provided this is leading us somewhere. Sooner or later, however, doubt may creep into the patient's mind. Even the most voluble patient may pull himself together and ask for instructions. If he should do so, provided the situation is favourable to analytical progress, I am still inclined to put him

off by some such superficial reassurance as "Just go on talking", "Just tell me the trouble", "You are doing all right". If he is not satisfied I go a step further and suggest that he tells me whatever comes into his mind.

Eventually, however, it will be necessary to tell him the rule, practically the only positive rule of psycho-analysis for the patient. That is: to say whatever comes into his mind irrespective of emotional or other valuation. In some cases, however, explanation may be necessary. In that case I may say to him, "Just relax your body, don't worry to think of anything to say to me. Let your mind be a blank if you like, and when you find it dwelling upon any matter, when you become conscious of any thought or any feeling, just put it into words so that I may know what you are thinking and what you are feeling. That is all." Occasionally it becomes necessary to enter into further explanation. For instance, one might have to explain to a patient that in ordinary conversation we direct our thoughts to a definite goal and censor irrelevant material, whereas in free association this is just what we are asked not to do. We should say any thought that comes even if it seems irrelevant or absurd or distasteful.

In spite of arguments with colleagues, I still feel that it is better to say as little as possible even along the above lines to a patient at one of his earliest sessions. He is apt to grab hold of some little word, such as the word "distasteful" and think he is under an obligation to select distasteful things and tell you. This may cause him a good deal of unnecessary discomfort, for at a later stage these things will all emerge naturally without his having voluntarily to challenge his own resistances.

Also it is fairly safe to say that, once this fundamental rule of free association of thought has been propounded by the analyst and consciously accepted by the patient, a large part of the analyst's work will consist in noting the patient's attempts to circumvent it, of puzzling as to how long he shall permit such circumvention, considering as to when the time is ripe to call attention to it, and so on: for, throughout the whole process of analysis the analyst has before his mind the main purpose of the process, which is not merely that of symptom-analysis or tracing the symptoms back to their earlier or earliest stage, but simply and solely dealing with resistances as they arise in order to let the patient continue free association of thought which is a

natural process of uncovering the repressed or resisted material and thereby, and—this is the main point—pursuing his strategic technique for the development of transference and subsequently for its analysis.

Other general principles which experience has found advisable are that there should be *daily sessions of fifty minutes each with a minimum of five sessions a week*. Most psycho-analysts insist that any form of psychotherapy which begins with less than five sessions a week is not psycho-analysis. According to them it may be one of two other things—incomplete or superficial analysis, or interminable analysis. The point is that the transference situation will develop much more slowly. Transference elements may accumulate during the intervals, and, particularly in so far as they are of a negative nature, remain inadequately expressed, with the result that they may find expression in action instead of in analysis—such action, for instance, as good reasons for concluding treatment, either on the illusion that it is making no progress or that progress is complete. In trying to explain to a patient the necessity for daily sessions at the beginning of an ambitious programme of deep analysis, I draw the analogy of reading a book and suggest to him that if he limited his reading to, say, one hour a week it is quite likely that in the interim period he would have lost the thread so completely that his interest would fade and he would forget to continue. Nevertheless in my experience I must admit that I have had patients who have done better, and made more progress on true analytical lines, on three sessions a week than some others have made on six.

The fourth principle is that of the *recumbent position*. With some patients it may be difficult to begin this early unless it is explained at the end of the first interview and adopted at the second. The object is to obtain complete repose for the patient both physically and mentally, and I may add at the same time to obtain sufficient necessary relaxation of the mind for the analyst, so that he has not all the time to be on guard against his facial expression revealing any affect, such as increase or diminution of interest; for, however well analysed he may be, the situation of having to look somebody in the eye for a succession of eight hours a day may detract from his ability to devote his whole mental concentration to the unconscious meaning of what the patient is saying, or not saying. At the same

time, general physical relaxation for the patient favours mental relaxation. The analyst sits where he can observe without being observed, where he can analyse without having to be on the defensive against the patient occupying his entire session in attempts to analyse him.

This is as far as I go in the application to the patient of the general principles of psycho-analysis. I think further interferences with the patient's freedom, such as not allowing him to smoke, are unnecessary, at least in the early stages, as the affect aroused by such an order may be more injurious to transference progress than the immediate relief of gratifying his habit. If a patient who is not ordinarily a smoker asks if he may smoke, I always say he may if at the same time he recognises that it is preferable that his feelings should obtain their expression through the analysis than for them to be temporarily soothed. At the same time, if smoking, like any other habit such as scratching or fidgeting, should be detracting from analytical progress, one naturally calls attention to the fact. It is then sometimes very revealing to suggest to the patient that he first deliberately stops the habit and, while resisting the impulse to do it, does free association of thought to the resulting tension. Commonly he will find that the association of thought is to early habits of fiddling with his body, specifically to infantile masturbation, and to the tensions he was relieving thereby and to their relationship with his current state of tension.

Now the passivity of the analyst and the acceptance of the fundamental rule of free association of thought by the patient initiate a situation in which we can observe the interplay of opposing psychological forces. On the one hand it is natural, when all physical or muscular forms of expression are denied and verbal expression encouraged, for libidinal tensions to tend to relieve themselves in the form of speech. The analyst is watching this process and at the same time he is watching the operations of an array of opposing forces (resistances) at all levels. At the early stages of analysis perhaps the most conspicuous of these may be operating through the ego. The force which tends to free association of thought is "libido". It is a drive regarded as emanating from the id. The second, or opposing force, is what psycho-analysis is mainly concerned with and is technically termed "defence-resistance".

It is important to recognise that difficulties that arise in the course of an analysis are not all defence-resistance, for this is only one side of the picture—the patient's side. The difficulties that arise may be divided first of all into (1) those inherent in the analyst and (2) those inherent in the patient (analysand). Some of the latter I shall mention under the various stages of analysis. Those inherent in the analyst are more important but are more difficult to explain from this angle. It would be a little easier to describe them after the difficulties inherent in the patient have been surveyed, as essentially they will be the same difficulties. The analyst should himself have been an analysand at one time and his difficulties should have been dealt with in the same way as he is now proposing to deal with those of the patient. Nevertheless it is more than likely that under the analytical situation a certain reactivation of them may tend to arise, and he will, throughout the process of conducting an analysis, have to recognise the difficulties which his own mind is presenting and so retarding his ability to deal perfectly with the patient's difficulties. He will fail to recognise material in his patient which eluded him in his own analysis. He may even unconsciously aid and abet his patient to keep important affects from emerging.

Further, if he has been analysed it is likely that he has developed a considerable psychological sense. This will enable him to recognise behind every single expression or activity of his patient—or for that matter of any person abnormal or normal, inside or outside the analytical room—the operation of unconscious motives. That is to say, the presence of motives of which the actor is unaware. These motives are often revealed as much in the most rational-seeming activities as in the most unconscious accidents, slips or mistakes. For instance, if a man finds his wife suitable or unsuitable may be due as much or more to unconscious complexes within himself as to the fact of her being a good or a bad wife. Whatever attitudes he may adopt to persons or things or to himself, there are in any case unconscious forces at work within him that cause him to adopt the attitude he does adopt. All this simply amounts to saying that the analyst must have learnt that the scientific canon of cause and effect is just as certainly operative in mental phenomena, however subjective, as it is in physical phenomena. Though this may be more transparently clear in the case of

psychoneurotic illness with its symptom-formation, it is just as certainly true of *every* feeling, thought, judgment and action. The analytical process is directed to the person's mind as a whole and may utilise the phenomena of symptoms only in so far as these assist in the general process of removing resistances and revealing the unconscious source, no less of the patient's attitudes and behaviour than of his symptom-formations. Psycho-analysis shows that these are inseparable parts of one integral whole.

Although all the analyst's real difficulties reside in his own unconscious mechanisms, the most serious form in which these are likely to express themselves is in the form of what is called counter-resistance and counter-transference. It is a good rule for incompletely analysed therapists to refuse to treat a patient whom they have a tendency either to dislike or to react to rather emotionally in any way. Otherwise the unconscious operation of the analyst's counter-resistance or counter-transference is liable to cause a complete deadlock at some stage or other of the process whether his counter-affects obtain expression or remain rigidly repressed. The id is a wild animal, and you cannot tame or educate a wild animal by entering the "dog fight" with it, nor by being so preoccupied in muzzling your own "dog" that you are not free to deal appropriately with the other.

CHAPTER XXVIII

THE INSTRUMENT OF PSYCHO-ANALYSIS: TECHNIQUE (*contd.*)

We have dealt with general principles and mentioned some of the chief difficulties, and must now turn to a description of the process and progress of analysis from the point of view of *consecutive stages* in the application of technique.

Analysis is essentially a dynamic process which progresses steadily or jerkily throughout its course. The analyst must be alive to the sense of movement within it. What may appear to be arrests of movement are really accumulations of undischarged affect. These may burst forth periodically, to the surprise of the unwary analyst. Nevertheless, in spite of analysis being really a continuous process, it is helpful for descriptive purposes to divide it into theoretical stages. Although a certain amount of overlapping is inevitable it will help to clarify the technique if we discuss it under various headings.

First of all *the interview*. Unless we are purely and simply psycho-analysts and are in a position to refuse to see any patients who have not previously agreed with their doctor to undergo a course of psycho-analysis proper, we are at the disadvantage at a first interview of not knowing whether this will be a case we should subject to deep analysis or whether some temporary or extemporaneous help is all that will be practicable. In any event we will probably have to give the doctor some initial diagnosis or information and will therefore have to conduct our first interview roughly on the lines described in the chapter under Case-taking. But in so far as the patient's complaint or opening remarks indicate the possibility of his being a case for deep analysis, it is as well to bear in mind the principle of transference development.

Therefore the ordinary clinical interview may have to be somewhat modified to the extent of allowing the patient to tell his own story in his own words without interruption, however unsatisfactory or incomplete it may be. If very unsatisfactory or incomplete, we may effect a compromise that does not entirely

relinquish the possibilities of subsequent analysis. We cannot afford to insist upon making the patient keep to the point, as does the clinician in a case of organic disease, because we cannot afford to remain indifferent to the psychological tension that may be provoked thereby.

In general, apart from the principle of setting the patient as completely as possible at his ease, we prefer to leave the first real move to the patient, and may learn a great deal, perhaps the most essential points, from his choice of move and what subsequently emerges. I will give an illustration of what I mean: A business man once came to me to ask my advice about his maturing daughters, their phobias and difficulties and how he should deal with them. I soon suspected that this was not the real problem in his mind. His concern was himself; and he had come with this ready-made psychological defence, perhaps in order to "vet" me and to give himself further time for consideration as to whether he should trust me with the very secret matter that was really worrying him. Therefore, while I listened to his story about his daughters I was partly considering how strong were his resistances and how soon, or long, it would be before I learnt the real, suppressed purpose of his interview. In the meantime I thought it best to humour his defences, for I could see that his psychology was such that to say to him in effect "Stop this nonsense and tell me what you have really come for" would merely have aroused denial and perhaps indignation and certainly no progress. So I decided to take his questions more or less at their face value, and wondered if the succeeding appointment could be deferred for another half-hour, guessing, as proved to be the case, that he would broach the real subject when we arose to depart. This he duly did, and I promptly gave him another appointment at my next vacancy so that he would have sufficient time for so important a matter. From this little demonstration one might conclude that the resistances, at least the early resistances, that he would put up during the course of an analysis might well prove nearly insurmountable.

Thus in the first interview we may observe a great deal of evasion as well as the unconscious mechanism of displacement and sometimes condensation and secondary elaboration, in a patient's statement of his case. Finally, we may conclude with a few leading questions. But here we must be careful as any attempt to pry might soon mobilise the patient's defences.

CHAPTER XXVIII

THE INSTRUMENT OF PSYCHO-ANALYSIS: TECHNIQUE (*contd.*)

WE have dealt with general principles and mentioned some of the chief difficulties, and must now turn to a description of the process and progress of analysis from the point of view of *consecutive stages* in the application of technique.

Analysis is essentially a dynamic process which progresses steadily or jerkily throughout its course. The analyst must be alive to the sense of movement within it. What may appear to be arrests of movement are really accumulations of undischarged affect. These may burst forth periodically, to the surprise of the unwary analyst. Nevertheless, in spite of analysis being really a continuous process, it is helpful for descriptive purposes to divide it into theoretical stages. Although a certain amount of overlapping is inevitable it will help to clarify the technique if we discuss it under various headings.

First of all *the interview*. Unless we are purely and simply psycho-analysts and are in a position to refuse to see any patients who have not previously agreed with their doctor to undergo a course of psycho-analysis proper, we are at the disadvantage at a first interview of not knowing whether this will be a case we should subject to deep analysis or whether some temporary or extemporaneous help is all that will be practicable. In any event we will probably have to give the doctor some initial diagnosis or information and will therefore have to conduct our first interview roughly on the lines described in the chapter under Case-taking. But in so far as the patient's complaint or opening remarks indicate the possibility of his being a case for deep analysis, it is as well to bear in mind the principle of transference development.

Therefore the ordinary clinical interview may have to be somewhat modified to the extent of allowing the patient to tell his own story in his own words without interruption, however unsatisfactory or incomplete it may be. If very unsatisfactory or incomplete, we may effect a compromise that does not entirely

relinquish the possibilities of subsequent analysis. We cannot afford to insist upon making the patient keep to the point, as does the clinician in a case of organic disease, because we cannot afford to remain indifferent to the psychological tension that may be provoked thereby.

In general, apart from the principle of setting the patient as completely as possible at his ease, we prefer to leave the first real move to the patient, and may learn a great deal, perhaps the most essential points, from his choice of move and what subsequently emerges. I will give an illustration of what I mean: A business man once came to me to ask my advice about his maturing daughters, their phobias and difficulties and how he should deal with them. I soon suspected that this was not the real problem in his mind. His concern was himself; and he had come with this ready-made psychological defence, perhaps in order to "vet" me and to give himself further time for consideration as to whether he should trust me with the very secret matter that was really worrying him. Therefore, while I listened to his story about his daughters I was partly considering how strong were his resistances and how soon, or long, it would be before I learnt the real, suppressed purpose of his interview. In the meantime I thought it best to humour his defences, for I could see that his psychology was such that to say to him in effect "Stop this nonsense and tell me what you have really come for" would merely have aroused denial and perhaps indignation and certainly no progress. So I decided to take his questions more or less at their face value, and wondered if the succeeding appointment could be deferred for another half-hour, guessing, as proved to be the case, that he would broach the real subject when we arose to depart. This he duly did, and I promptly gave him another appointment at my next vacancy so that he would have sufficient time for so important a matter. From this little demonstration one might conclude that the resistances, at least the early resistances, that he would put up during the course of an analysis might well prove nearly insurmountable.

Thus in the first interview we may observe a great deal of evasion as well as the unconscious mechanism of displacement and sometimes condensation and secondary elaboration, in a patient's statement of his case. Finally, we may conclude with a few leading questions. But here we must be careful as any attempt to pry might soon mobilise the patient's defences.

Further, one may say that it is not good analysis to offer psychopathological explanations to a patient at the first or early interviews unless you can be sure that your interpretation will be welcome to every part of his psyche. Such was the case in the patient I described in a previous chapter who was castigating herself for stupidity when her only real stupidity had been not to see that her husband was voicing the criticisms of his sister. Interpretations that take insufficient cognisance of the patient's resistances, if true and far-reaching, may increase his anxiety and you may never see him again. This is what has been called "wild analysis". It tends to rob the patient of a necessary libidinal expression while offering him nothing in place of it. Such a process may either effect no change in the patient except that of fear or hatred for the analyst, or else it may increase his defences and cause him to grow worse and develop an alternative neurotic illness.

Some patients are inclined to ask many questions. This is usually a manifestation of anxiety and the analyst must never think that it is his duty to answer questions on their face value. He must recognise what lies behind the questions and perhaps make some attempt to deal with *that*, otherwise his only course may be to offer the minimum of explanation that is calculated to allay the patient's anxiety and thereby to get him talking again. However, at a first interview some regard has to be taken of conscious levels and the analyst must be careful not to mislead the patient or to tell him any untruths. He is almost certain to ask how long the analysis will last. No attempt should be made to answer this question except by confessing "We do not know". If pressed we may defer the matter by saying that a rough indication may be given, but only after several weeks of analysis.

Some analysts make a point of telling their patient that if analysis is decided upon he must promise to make no important irrevocable commitment, specifically engagement or marriage, while the analysis is in progress, nor for at least three months after its termination. I remember only on one occasion giving this advice at a first interview and exacting a promise that it would be obeyed—and that was in the case of the only patient who left me to get engaged *and* married within six weeks of commencing treatment!

The question of times of attendance, of fees, of monthly payments, of the principle of hiring one's time irrespective of

whether the patient attends or not, and in some instances of vacations, etc., should all be dealt with at the preliminary interview. Patients who are inclined to put off the beginning of treatment to some later date may usually be written off immediately. They rarely return.

Now the three stages of analysis proper that I propose to describe may be classified in accordance with the concept of the *libido* in the following way: (1) the pre-transference stage, (2) the stage of transference neurosis, and (3) the terminal stage of resolution of the transference. Or these same stages may be named from an ego point of view as follows: (1) the stage of relaxing the unnecessary censorship of the super-ego, (2) the stage of analysis of super-ego development and structure, and (3) the transferring of the function of the super-ego over to the jurisdiction of the ego, so that the ego instead of the super-ego may hold sway over the balance between libidinal drive and reality consideration. A definition of these terms, if the reader is unfamiliar with them, will be found in the glossary.

I. THE PRE-TRANSFERENCE STAGE

Even the inexperienced analyst may manage this stage with some degree of success provided he is sufficiently passive and shows no affective reaction. Where he is likely to fail will be at the following or transference stage, but I am afraid failure *there* will, in the psycho-analytical sense, be fundamental. Remembering what has been said under general principles regarding passivity and the analytical rule of free association, the analyst's business during this stage is simply to set the patient sufficiently at ease so that he does free association of thought as freely as possible, and to keep him doing it without any unnecessary interference. Interference becomes necessary whenever the patient is unduly held up. The analyst notices the main trend of the patient's unconscious material and particularly his main types of defence. At the same time he observes the amount of affect, suppressed or otherwise, which accompanies the associations.

Sooner or later difficulties are sure to arise. Every patient coming for analysis will require assistance. The analyst must know when and how to assist. To do this he must understand the patient's difficulties and must be able to help him over them. He should not do so until the patient has himself become

aware of his difficulties. The most relevant assistance he will then give will probably be that of interpreting whatever unconscious force is responsible for holding the patient up. At a very early stage it may on occasions only be possible to appreciate that it is anxiety, and to resort to reassurances or other means of relieving the anxiety until one is in a position to interpret its causes. The factors that interfere with free association of thought at this stage are almost always anxiety factors, and their mechanisms will be dealt with under the heading of defence-resistance. Suffice it to say here that the factors that facilitate free association are the inviting passivity of the analyst and his tolerant and non-critical attitude.

But in spite of this, anxiety will arise and the analyst must do just sufficient to allay it and no more. When the patient speaks the analyst is silent again. The amount of interference must never exceed that required to aid the process of free association. At each interpretation, or even at each continued silence, the analyst should be sure that it is purely the analytical needs of the patient that are influencing him (either in speaking or in allowing the silences to continue for a time), and not his own analytical needs. There should be no compulsion within him to be exhibitionistic, to try to make a good impression upon the patient, or to be sadistic or anything else which is irrelevant to his only function, that of removing resistances to the patient's free association of thought. The situation is not one designed to relieve the analyst of his own repressed affects; that should take place in his ordinary life and should have been exposed to him in the course of his own analysis. Such needs of the analyst are detrimental, not helpful, to the patient. *Per contra*, reaction-formations within the analyst may be disabling to his ability to render the appropriate help.

While resistances are being removed and free association is proceeding to gradually deepening levels, a certain change in the emotional disposition of the patient is taking place. It will be found that his super-ego is undergoing modification and that he is gradually identifying himself with the analyst. Intellectual changes achieve nothing, it is these emotional changes that count, for emotions are the dynamic forces responsible for the neurosis and in the absence of such changes there is no analysis. In short, even during this first stage of analysis, libido is being freed from a state of repression, the analyst is taking the place

of the patient's super-ego and the freed libido is automatically attaching itself to him. The super-ego was formed by the introduction of parents and mentors (and their fantasised attributes, acquired by projection of the infant's aggression, etc.) and we are now witnessing the process *in reverse*. This is the essential change in the deeper levels of the patient's psyche which ushers in what is known as the second or transference stage of analysis.

In the meantime, while pursuing this strategic technique of arriving at transference, the analyst will have obtained a considerable insight both qualitatively and quantitatively into the patient's psychic structure. He will have noted various libidinal trends and various types of ego defence. He will have analysed many dreams and discovered various screenmemories. All this material he will treasure for future reference and for use in dealing with the transference, for in this stage he will require all his resources. The success of the analysis depends upon the handling of the transference.

2. THE TRANSFERENCE NEUROSIS

Transference may be defined as a specific displacement of affect, positive and negative, from one person (usually the parent) on to another person, e.g. the analyst, or it may be defined as a projection on to the analyst of affects originally experienced towards the parents during the period of infantile amnesia.

There are a number of ways in which the arrival of the transference situation may manifest itself. It may come about so insidiously that neither analyst nor patient can definitely state any point at which it arrived, but may only know that it certainly has arrived. Or it may be ushered in quite dramatically. The latter event is, of course, indicative that it has been accumulating unseen for some time previously.

One of the common premonitory signs of developing transference neurosis is a tendency on the part of the patient to forget his symptoms and previous complaints, to cease to produce memories of his past, and instead to take to a process of telling the analyst in great detail all the events, objective and subjective, which have happened to him during the last twenty-four hours, or since his last session. This habit may continue for some little time until a moment arrives when the patient just lies on the settee with nothing whatever to say. The analyst, having met all these phenomena before, will recognise that libido, since

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the early stages of treatment were passed, has ceased to go back regularly to early events in the patient's life, has on the contrary been moving steadily forwards into the more and more immediate present, and, now, with this advent of silence, has finally arrived at the very moment while the patient is lying on the settee!

Libido means immediate emotional interest. The patient's silence means that emotionally it does not matter now what has happened in the past twenty-four hours, the matter of emotional importance, the matter of emotional absorption is the present moment while he is lying on that settee in the analyst's presence. There is obviously nothing to talk about. It is happening here and now. You don't think of other things while you are experiencing the most important emotional events, however unconscious these may be. To understand what has happened we must understand what we mean by transference.

Transference is a transferring of the emotional life of the period of a person's infantile amnesia, an emotional life which was preoccupied with his feelings towards his parents, on to another person, in this instance the analyst, in the present day. I will explain this by an analogy with other and more recent instances of amnesia. For example, in a war neurosis if a soldier experiences a traumatic event which is so painful to his conscious mind that he simply cannot bear it, the psyche resorts to the primitive process of repression of the whole event and possibly of its surrounding circumstances from consciousness, and the soldier has an amnesia for the event and for that period of his war experience. How do we know that the whole thing has not really utterly disappeared out of mind altogether? We know for this reason: that years later he suffers from an anxiety state. Perhaps every little noise causes him to start or jump, or perhaps some specific event, unconsciously associated with the trauma he experienced, creates a reaction in him, inexplicable except in terms of the forgotten experiences which caused his amnesia. In short, the affects which he felt at the time of the trauma are constantly breaking out from repression, although the actual events or memories originally connected with those affects remain successfully repressed. There is free-floating anxiety for ever emerging into consciousness and for ever tending to attach itself to the irrelevant events of the present day. Under analysis, even a superficial analysis in such cases, the repressed memories

are brought back into consciousness and the patient eventually discovers to what experiences his fright really belongs. This will help him to recognise that it does not belong to the present-day happenings; and this undoing of his period of amnesia, in other words the substitution of the memory, may take the place of the previously inexplicable state of current anxiety.

Now, there is evidence that we are all suffering from a very big amnesia, a complete blackout of the earliest years of our life when the very emotional patterns which form the core of our being were actually in process of formation. The affects we then felt were those of our developing instinct-based desires, frustrations, loves and hates for things and persons in our vicinity. What the trauma was that caused the total repression of the memories of these most impressive of all events that we could ever encounter, psycho-analysis has revealed. It was a trauma that belonged to the unreal emotional world which at that time was of far more significance to us than the only-just-beginning-to-develop reality world of our present-day conscious preoccupations. This trauma was just as effective as a nearly fatal accident, although it was essentially subjectively caused. It came about when we as infants found ourselves in an intolerable state of emotional turmoil and conflict owing to the opposing pressures of our love, hate and consequent fear. In phantasy we gratified our desires—desires which evidently included destruction of the very loved persons who as frustrators prevented our gratification. Talion punishment was the order of our fantasies, and, in consequence, we found ourselves in phantasy “castrated”—the equivalent of our conscious concept of “destroyed”. The whole thing was too emotionally intense to be borne. It was too traumatic. It became repressed. And with it were repressed practically all the memories connected with that early period of our life.

On account of the intolerability of the emotions connected with the Oedipus complex it will take a great deal to overcome the resistance to their emergence. On the other hand, they have formed emotional patterns within our mind analogous to the patterns phylogenetically inherited as instinct trends. The unconscious includes, as it were, a massive, complex “instinct pattern” very like, in many respects, the genuine inherited instincts which fill that instinct reservoir called the id. This Oedipus-complex “instinct pattern” will tend to relieve its

tensions in relation to some apparently appropriate person whom it takes to be a suitable successor of the original parent-figures in relation to whom it was formed. Therefore, like the war amnesia case, *living* its still repressed memories, it tends to discharge its affects, love, hate, fear, etc., upon the current situation and upon such symbols as it can find in the current situation, in lieu of the presence of the original events which incurred or stimulated these affects. So the war-amnesia soldier attaches his fear to present-day noises, and the infantile amnesia patient, or normal, attaches his loves, hates and fears to parent imagos, such as the analyst, in his present-day life. Until the amnesia is uncovered and the memories brought to light, neither the amnesic soldier nor the infantile-amnesic adult will have the slightest insight into why he is fearing, loving or hating what, to anyone but himself, appears to be inappropriate objects or persons.

We have thus arrived at an extraordinary phenomenon which only analytical insight will so much as suspect to be in existence, and alone realise that it is not only the essence of the situation, but emotionally the whole of the situation, however unconscious. The affective life of the transference situation is a dramatisation of the Oedipus complex. The analyst, whilst accumulating material throughout the previous stage descriptive of the patient's fundamental emotional patterns, has at the same time been watching the development of this transference neurosis. Now that it has arrived, what is he going to do about it? The important thing is that he should be fully, and in an analytical sense, himself aware of what it is and what it means, without having any doubts about its reality and without knowing it simply as a tale that is told. He must know it in a full analytical sense, that is with absolute inner conviction and familiarity. Then, and then only, in the light of its full appreciation, will he be able to treat it appropriately with entire freedom from interest or anxiety on his part.

In short, "I know that, once it commences everything that takes constantly breaks in analytical session, every thought, gesture, action, events or memories the patient, no matter to what subject, and main successfully repatient displays, is related to nothing more ever emerging into transference situation. The patient is, in fact, itself to the irrelevant a dramatisation of her original Oedipus even a superficial analysants. Knowing this, the analyst is at

liberty to break in with any and every transference interpretation which occurs to him. Unlike the position during the previous stages of analysis, he can do no harm by any interpretation which he makes. The point is that he cannot afford to leave the situation alone, uninterpreted. The palmy days of his passive rôle have come to an end never to return. Now he must be active and uncover this most important of all defence-resistance measures. He must interpret freely and not be put off by the patient's denials, however violent. The more violent they are the more they signify the unconscious "yes". He need not argue or press his points. He can afford to observe calmly the effects his remarks produce even if such effects are violent fury as well as denial. But he does not interpret purposely to arouse anger, nor in any case does he insist upon the patient consciously accepting his remarks. Her denials signify that he has disturbed some affect in her unconscious to which she is as yet consciously resistant. However, at this stage nothing the analyst says is likely to drive her from analysis; she is as firmly fixed to him and it as she was emotionally fixed in infancy to her parents. However, she herself is incapable, unaided, of obtaining insight into the situation, and whether uncomfortable on account of negative trends, or comfortable on account of positive, in it she will tend to remain more or less unchanged until the analyst has interpreted the unconscious material responsible for it, and until she finally obtains insight into it and uncovers the infantile memories, the affects of which she is at present unconsciously re-experiencing.

As this is such a particularly difficult stage of analysis to describe theoretically I will now proceed, in accordance with the policy of this book on clinical psychology, to a clinical excerpt which details the sort of material as it occurred during analysis.

CHAPTER XXIX

TWO EXAMPLES OF TRANSFERENCE ANALYSIS

EVERY analyst is familiar with the patient who endures long silences during his sessions and is acutely uncomfortable the whole time.

A protracted silence is usually caused by a state of acute anxiety. The patient is going through an unconscious phantasy of a terrifying nature. All he is conscious of is the resultant anxiety, which makes him quite speechless and arrests his mental processes. It is imperative for the analyst to discover and interpret this phantasy in order to relieve the anxiety and enable the patient to continue his free association of thought.

The striking peculiarity about the present case is that the conscious experience is *not* one of anxiety, but on the contrary sublime contentment.

This is unusual. The phantasy with which this patient is preoccupied is as unknown, both to her and the analyst, as is the phantasy of the usual anxiety-ridden patient. In both cases, unless this phantasy can be discovered and revealed analytically, progress—if not attendance itself—will cease.

She is content to lie upon the analytical settee without saying a word. She is a woman of forty. I ask her:

“What are you experiencing? You must tell me what is going on in your mind.”

She replies: “I am feeling perfectly all right, doctor, only I have no thoughts and therefore nothing to say to you. . . . No, I am not feeling uncomfortable. On the contrary, this is the first time today that I have felt really peaceful and contented. It doesn’t seem to me that there is any need to talk. To tell you the truth, I wouldn’t know what to talk about.”

The question the analyst has to put to himself is: *Why is this patient satisfied to spend this hour with me in silence?*

(It is essential that the analyst himself should not be the victim of any unconscious phantasy—anxiety-ridden or contentment-giving.)

While he sits there, silent, racking his brains to discover an answer to this question, he goes over in his mind all the information, great and little, which this patient has given to him in the preliminary sessions before this phenomenon of silence supervened.

Has there been anything identical with this, or equivalent to it, in the history of this patient's past life?

A number of striking instances come to mind. The analyst remembers that he was struck with the story of how this patient as a little child used to hurry home from school in a state of acute discomfort or anxiety, with only one object in mind. This object was to find her daddy. She had told me:

"I could not rest until I found him. As soon as I got home, if he were not there, I would ask, 'Where is Daddy?' Then I would run across to his workshop. I did not need to speak to him. I would merely stand beside him in silence while he went on with his work. But the difference it made to me was immense. All my restlessness and anxiety would have gone, and I would be perfectly content just to be with him. No words were necessary."

On another occasion this patient had told me:

"When I was eight or nine years of age, mother had arranged to take us all to the seaside for our summer holidays. At the last moment it transpired that daddy had to remain at home to continue his work. I showed such great disappointment that mother teasingly suggested that I should stay behind too. To her astonishment I jumped at it. It seems that seaside holidays were nothing to me. One thing only mattered—daddy!"

"I was a very emotional, highly-strung girl—perhaps one should say passionate—and it seems that I was always in a restless state, seaside or no seaside, unless I was near my daddy. His presence was the only thing that relieved my constant agitation and discomfort."

When the patient will not talk it becomes in due course, though not immediately, the duty of the analyst to do a little talking . . . though not until he has done a great deal of thinking.

These incidents from her past life just recorded are brought to her notice. She was then only eight or nine years of age. It is pointed out to her that though she is now forty she is similarly content to leave all her other obligations in life in order to come to her analyst and to lie silently in his presence.

If the past tells us something about the present, the present

may tell us a great deal more about the past. What is going on here and now while this usually restless, worried woman lies in this state of complete restfulness and utter contentment?

Let us answer this question first before we ask what was going on when the little girl of nine or earlier stood beside her daddy in a similar state of contentment. She cannot tell us. The phantasy, for phantasy it must be, is unconscious. However, she inadvertently gives us a few clues as to its nature. She says:

"While you were talking, doctor, I was not listening to what you were saying, but the sound of your voice was producing feelings of even greater contentment in me than I ordinarily feel lying here in silence. And when suddenly you leant forward in your chair I got an acute feeling in my stomach which made me catch my breath. I wish you would just go on talking all the time, and not expect me to say anything. I feel somehow that it would be so soothing to me that I should soon get quite well."

But this is not the whole truth: she does not always want me to speak any more than she wants to speak herself. My presence alone, even in silence, is having a very soothing effect upon her usual state of nervous agitation. It is evident that my presence, whether silent or speaking, is causing her to be soothed through the agency of some phantasy which she prefers to keep unconscious.

It would not be psycho-analysis to allow such a situation to remain unconscious. When it is brought home to her that the source of this contentment is unconscious sexual phantasy, two interesting things happen: (1) Firstly, she recognises the fact and obtains insight into it, namely, that she is lying there enjoying erotic feelings, and that these are the source of the soothing and the contentment. (2) Secondly, having recognised this fact, the whole situation is spoilt, and she is quite unable to go on with this satisfying procedure. Something in her will not permit it to continue.

This is but another instance of a frequently encountered analytical experience: that all sorts of enjoyable things (including, I may say, health itself) may be freely enjoyed in accordance with well-established instinct patterns, only provided they remain unseen or unsuspected by some potentially interfering, watching force—conscience or parent.

We may pause here to ask what the little girl of eight or nine was doing in her anxiety to find her daddy, and what was the

source of this contentment which caused her to prefer his presence to seaside holidays.

While she was with him this otherwise neurotic child suffered from no neurosis and remained perfectly healthy and happy. Similarly, while she could come to her analyst frequently and experience an hour of silent contentment, she was quite happy—at least, such was the position before the source of the happiness was interpreted.

As relief or cure was such a simple matter, why had this patient ever become ill? Her illness was precipitated by a withdrawal or deprivation of the source of relief. This happened during her session, when, as a result of the interpretation, she herself stopped or suppressed the phantasy which was soothing her nervous condition.

Her illness itself was originally precipitated at the age of twelve by the intervention of tragedy, a tragedy which deprived her of what was then her only source of relief from tension. Her father met his death in a street accident.

It should be pointed out that the significance of her father's death in relation to her illness was purely the rôle he was then playing in her necessary reduction of tension, however unconscious this process may have been.

This patient claims to have no recollection of any event in her life for the subsequent three and a half years. She says:

"I don't remember anything that happened to me from that time until I was sixteen years of age."

Nevertheless, subsequent analysis brings to light several startling incidents that took place during this three and a half years, and which had been repressed from memory. It is not without significance that these forgotten incidents (and the fact that they ever occurred) were a succession of sexual traumata.

Why was it that men who had been friends of her father, and who were now friends of her widowed mother, appear to have stimulated erotic experiences or erotic fantasies in this patient when she was barely thirteen years of age?

Why is it that hysterical children produce an abundance of such memories, quite out of proportion to those produced by so-called normal children?

Perhaps the answer is that unconsciously they are seeking to call to themselves such selective experiences. And the evidence goes to show that, even if they cannot have them in actuality,

they make up for it by having them in phantasy, or even hallucinating them. Psychologically the results seem to be identical in either case.

Be that as it may, analysis of this patient revealed that these several years of amnesia (memory-blank) were crowded with a succession of childhood sexual experiences, real or imaginary. Compare these facts with the present behaviour of this extremely hysterical woman. She lies on the analytical settee in complete silence, perfectly content and, as it transpires, enjoying erotic phantasies. She is unconsciously inviting erotic advances.

Evidently this is what she was doing at the age of twelve or thirteen. Her father, in whose presence she similarly enjoyed perfect contentment, had died, and although she had blotted out the effects by a period of amnesia, she had immediately and subsequently invited and experienced a succession of erotic advances, real or imaginary.

The period of so-called amnesia eventually passed at the age of sixteen, when she recalls a particularly vivid experience of rape. She portrayed herself as an innocent victim of this tragedy.

A little more analytical insight revealed to her that, although she is now forty, she is still urgently inviting this rape: I notice that since the source of her silent happiness during analysis was interpreted, she has assumed a new posture on the settee—instead of lying on her back she now lies half on her side with her legs crossed and one foot very near the floor. Incidentally, in this position she can keep at least half an eye on the analyst seated behind her.

When her attention is drawn to these changes, she objects that she would find the former position quite intolerable, and if I insisted upon her assuming it she would cease to attend.

Nevertheless, at the next session, without a word from me, I notice she is lying rigidly full upon her back! I call her attention to it, and she blames me, saying that I said I would refuse to analyse her unless she did it; but it is all wrong because in that position she cannot think of anything whatever to say. Her mind is in a state of complete mental confusion. All she is aware of is a throbbing in her throat. She is most acutely uncomfortable, and she will be so exhausted after one hour of this that she will not be able to think for days to come.

Then she says she feels like a pig hung up by one leg waiting to have its throat cut.

Presently she threatens reprisals. She says:

"You would be sorry if I got up and went for you for this treatment of me."

It was a pertinent question to ask her what she would attack me for. Her ego answered: "For making me do something I did not want to do, namely, lie on my back." She forgot, of course, that she had assumed this posture without any instruction on my part.

But the warmth of her handshake at the end of the session strongly suggested that the attack would not have been for anything that was done to her, but for the failure to do anything.

I have said that this woman's most vivid memory is that of rape, at the age of sixteen, and I have pointed out that, although she is now forty, she is still urgently inviting this rape. It should be added that rape it would certainly be, for she is most resistant to any sexual advance from any source whatsoever—not excepting her husband.

One can go further than this and point out that in the absence of this rape she phantasies or dreams it happening. Periodically she awakens in the night with a scream. Analysis reveals that she has dreamed or phantasized the act or the orgasm about to happen, and has sprung into resistive action, leaping out of her bed. This is conflict indeed.

One side of her nature brings about the sexual situation, real or imaginary, and the other side leaps into activity to save her from it. These tendencies are all revealed in the course of analysis. Her life reveals that she has projected her conflict into the world of reality around her. She has a husband, but she never obtains relief; that can be approximated to only provided she is unconscious of the phantasy that is soothing her—that is, moving her in the direction of relief without, of course, ever achieving it.

On the one hand her accumulated libidinal tensions are enjoying phantasies of tumescence and detumescence at the hands of the father image, while at the same time the psychology of the child of twelve or earlier is terrified of any actual sexual advance, and is above all other things terrified of a complete reduction of tension in the form of orgasm.

In practice this woman has always been completely frigid with her husband, while she seeks to reconstruct the situation of the little girl with her daddy.

It is with her analyst only that her phantasies assume a pleasurable erotic quality and cause her to remain in his presence in a state of perfect contentment, experiencing this fullness of satisfaction which alone relieves her of all her current anxieties and hysteria.

Bringing this unconscious dramatisation to consciousness is the only way that she will be in a position to free herself from its constant domination over her thoughts, feelings and actions, and to direct her own love life and its needs—instead of being directed by unconscious forces which belong to childhood and the child-parent relationship.

Readers who are not psycho-analysts may think that this analytical situation occurring with a female patient in the presence of a male analyst may be understandable, but they may assume that there could be nothing equivalent to it in the case of patient and analyst being of the same sex. They may wish to ask what happens in the case of a male patient when he reaches the transference stage.

In accordance with the method adopted throughout this work on clinical psychology I shall reply with an example. The following is an excerpt from the analysis of a male patient of about fifty years of age who had reached a stage of his analysis when, like the woman above quoted, he found little or nothing to say. It was evident that deep interpretation would have to be applied if only to avoid almost immediate analytical failure. With some encouragement on the part of the analyst the patient at last was induced to give expression to his growing dissatisfaction with the whole process. He said it was not a form of treatment that seemed to suit his particular case. He had tried his best to follow the directions of free association of thought but manifestly it was not getting him anywhere and he could not see how it would ever do so.

Of course, it is not part of the analytical technique to enter into any argument or discussion on such issues. So long as a patient is giving expression to such thoughts, however negative, one should be content to encourage him to continue, biding one's time for interpretation. But the position in this session was worse, for the patient's complaints even soon ran dry and one was again faced with a rather obstinate or persistent silence. When pressed to continue free association of thought he said he

could only repeat what he had already said, namely, that his mind was either completely *blank* or else it was active purely on a conscious plane. By a conscious plane he meant in regard to thoughts about his immediate surroundings, the interior decoration of the room, faint noises from the street and so on, matters which he said even he could see it was a pure waste of time to talk about; therefore, he argued, as nothing came up from within his mind, he might as well be silent, or, better still, discontinue attendance.

Fortunately such crises are unlikely to arrive before the analyst has gained some knowledge of a number of facets in the patient's emotional make-up or of a considerable variety of his emotional patterns. Seeing that the son-father situation had not yet been brought to a conscious level in this case, and appreciating that there was a situation between two males which led to this deadlock, I tried the bold stroke of interpreting his unconscious streak of homosexuality.

I said with due emphasis, "*Your blankness is due to the inhibition of homosexual phantasy.*"

The patient thought for a moment and then said, "I have lain quiet and I have certainly found that everything was blank, but beyond that I am not aware of any homosexual phantasies."

Analyst, bearing in mind certain past instances in the patient's life which had emerged at previous sessions: "*What thought would go on if you rested, for instance, in a field together with that young man of twenty whom you have previously mentioned to me?*"

Patient, slowly and exhibiting signs of very tense emotion: "I should be wanting to make closer contact with him. The thought would be the position I should want. But I would not let him know that. I would be lying there silent, hoping all the time that he would wish to make contact with me. I should not like to take the initiative for fear of finding that it was a shock to him."

ANALYST: "*Now let us compare that situation with the situation here with me. What is the difference?*"

Patient after a short silence laughs loudly and says: "It is very different. There is all the difference in the world."

ANALYST: "*What difference?*"

PATIENT: "Just that there is no feeling of . . . well, I mean there is no repulsion, but at the same time there is not that draw. In short, there is neither repulsion nor attraction."

ANALYST, emphatically: "Now you have said it. What you have said is that from an emotional point of view this situation is quite useless."

PATIENT: "Yes, certainly it is emotionally useless."

ANALYST: "And that is what you said of the analysis. A useless expenditure indeed! The other thing that you have said is that with an appropriate love-object it would not seem useless. If you were with the young man, the last thing you would be concerned about would be the uselessness of the situation, however silent."

PATIENT, thoughtfully: "I have felt sometimes that I have looked forward to coming here . . . from the point of view that I was glad to tell you things about myself, things that I have not been able to tell anyone else. It is only just recently, perhaps only at this very session, that I have now become a little disappointed and wondered if we were getting anywhere. Perhaps I had hoped that when I told you all I could think of you would then start something." He hurriedly added: "Of course, now I see that actually you are doing so. At the moment it seems to me that after we have hung fire you have now started something moving again, and at the moment I do not feel the objection I was voicing a little while ago. I feel we are getting on."

At this point I offered a second interpretation. It was this: "*As you have said your dissatisfaction meant that the analytical situation had hung fire. In terms of emotion this means that recently there has been inadequate libidinal release, or if we put it in ego terms we would say inadequate progress.*"

PATIENT: "I am thinking that when I finish work and go home and am by myself I feel restless, like I was feeling here. My tendency is to go out of the house. I suppose it must be in search of something—goodness knows what. I am now thinking that what leads one away is search for a kindred spirit, and now it occurs to me that when that young man was in the house I was different, I did not then want to dash off anywhere in search of something as I tend to do now. Now I do not settle down, not even to letters. I want to go somewhere in search of, I suppose, companionship. You have brought it to my notice that one is restless if one is not being emotionally gratified, or at least anticipating the possibility of emotional gratification, so restless that one has to seek something we call companionship, something which may offer, however faintly and distantly, some prospect of achieving emotional fulfilment."

At this point the session ended. This little excerpt is given to illustrate deep and perhaps rather difficult transference interpretation and its effects upon the progress of analysis. A point worth emphasising is that analytical progress is synonymous with libidinal release. We are familiar with the phenomenon of a patient early in analysis acquiring so much unaccustomed libidinal release that he rushes off and gets himself engaged or married, instead of as we had wished using the newly acquired libidinal energy released by the treatment to bind him closer to his analysis and its progress. I have often heard it said by experienced analysts that it is deep interpretation which keeps the patient. This is because deep interpretation if opportune causes libidinal release, and libidinal release within the analysis is comparable to sexual progress. The young man who is making progress in his courtship of the lady does not leave her, any more than the hound leaves the trail when it is hot on the scent. In his unconscious this is because instinctual energy is scenting gratification. There is thus a close relationship between instinct release in the real world and the release of emotions from repression in the analysis.

Therefore both instinct gratification and analysis relieve the bottled-up libidinal tension and so discharge the energy which is causing intra-psychic stress and symptoms. The difference between successful analysis and successful instinct life is that in analysis the tensions are relieved by the *mental* process through the undoing of the repressing forces either by free association of thought, or, when the resistances are too great for this to succeed, by deep interpretation. In consequence of this release the repressed unconscious material emerges into consciousness and to that extent tends to come under the direction of the ego instead of breaking or disrupting the ego.

It is necessary for the would-be analyst to have been analysed, as only as a result of his experiences while undergoing that process will he have ceased to be afraid to sense and to feel emotions which the patient is afraid to feel, and only that will enable him boldly and confidently to give the correct interpretation of deeply unconscious material.

CHAPTER XXX

THE TERMINAL STAGE

The last, or terminal, stage of analysis presents us with almost as many difficulties as the transference stage. Most patients are content to remain in the transference stage of analysis. They are so content that they manifest no desire to alter it and, indeed, offer strong resistance to attempts on the part of the analyst to do so. This phenomenon is not peculiar to the analytical situation. It appears unrecognised in every walk of life. In general practice, patients insist on treating themselves by means of transference, and the doctor, consciously or unconsciously, encourages them to do so. Lawyers and priests similarly accept the transference of their clientele or parishioners, and it seldom occurs to any of these persons that they should endeavour to dissolve it. A continuation of his patients' transferences with their resultant weekly or bi-weekly attendances in his surgery—a habit which they are likely to continue to their dying day—is a state of affairs which the general practitioner accepts with the calm and equanimity born of great familiarity.

The psycho-analyst on the other hand holds the view that transference continuation represents a stalemate in the patient's power to effect a more stable adaptation of his emotional needs to his reality life. The problem that presents itself to the analyst is when to initiate the terminal stage of analysis by telling the patient that it is drawing to a close and that he proposes to discontinue it in a few months' time.

In the meantime, through his interpretations of transference he is reconstructing the development of the infantile emotional patterns and by his interpretations of transference resistance he has exposed the infantile ego's original fears. Thus he has conducted deep libido analysis and deep ego analysis. While he has been doing this he will have observed two classes of events.

One is a tendency of the patient to regress emotionally to his infancy or babyhood—very often even some baby habits will have displayed themselves during analysis. I have known

patients to take to lying in the position they occupied in their cot; to walk in a babyish fashion in the analytical room, and so on.

The other class of events which he will have noticed is of an opposite nature, namely, a tendency for the patient to divert his emotional interests to extra-analytical preoccupations. It will be noticeable that he is beginning to live more in the reality world outside the analytical room. He may have ideas of marriage or of starting a new business and may even have gone so far as himself to suggest a slacking-off of the analysis.

But the analyst must take the situation as a whole into account and must base his decision to initiate termination not only upon these phenomena but also upon the question as to whether he has adequately uncovered the Oedipus complex, and, in some cases, the pre-Oedipus situations that preceded the development of the organised Oedipus situation.

The terminal stage, even more than the transference stage, usually arrives more or less insidiously. When established it is a stage characterised by two important processes. One of these we may call "*libidinal weaning*", which means the encouragement of the patient to divert his emotional interests into extra-analytical fields. The other we may call "*ego education*". This means that the patient's ego is encouraged to take over the direct control of his instinctual life in place of the previous directors of this life. The first of these previous directors is his super-ego, with its characteristic archaic severity, which was in charge before he came to analysis, and, to a decreasing extent, throughout the early stages. The second is its successor, which he gradually put in its place, namely, the person of the analyst in lieu of the original parents.

As an example of ego education I am tempted to detail an analytical excerpt which is fresh in my mind as it occurred at a recent session.

After interpretation of a display of temper during his analytical session the patient said:

"I present the pattern of impotent rage just because it occurred in my infancy. It was punished, but that only caused me to hold it in. Here I have learnt to let it out again, but it is equally ineffective here; it brings me little satisfaction; it is like punching a feather bed—some momentary relief to one's feelings, but gets one nowhere."

ANALYST: "No doubt it is me you would like to punch. Would you like to destroy me?"

PATIENT: "No, perhaps that is what causes me to get into a panic. If I destroyed my mother because I was angry with her, I would have been terrified, however much momentary satisfaction it might have been. But how am I to get a new pattern to deal with this rage that surges up within me?"

ANALYST: "One has got to go back to the original pattern and unpick that before one has the threads with which to weave a new one."

PATIENT: "I cannot do that because it is in a knot. The only thing I experience at the moment is impotent rage, and I must either express it or suffer a feeling of utter impotence which I call submergence."

ANALYST: "What association of thought do you get to this feeling of impotent rage?"

PATIENT: "At school I was ragged and bullied unmercifully and simply did not know the appropriate pattern of reaction. It was the same when I thought that woman was bullying me the other day. It was either a question of flying off the handle—impotent rage—which would have caused regrets, or it was the alternative of repressing *everything* so that I was equally incapable of dealing appropriately with the situation."

ANALYST: "A present situation such as bullying provokes the old pattern. If all your energy were not absorbed in the resulting conflict (conflict between aggressive impulses and super-ego) then you could look at the thing objectively and say to your bullier: 'This is a very interesting phenomenon that you are displaying. Let us have your free association of thought to it!'

"The panic you spoke of is the fear that your ego will not be able to control the tendency to react with a display of violence or of impotent rage. At the same time, the energy of the rage, not being allowed an outlet, reinforces the feeling of anxiety. What you experience is, first, rage striving for satisfaction and, second, you find this outlet inappropriate, discover that your hands are tied and experience a feeling you call impotent rage. The appropriate reaction for which you are asking me is this: Having recognised these affects, to bow to the superior power of reality."

PATIENT: "Yes, that is what gets me—a difficulty in bowing to the superior forces of reality."

ANALYST: "You need a little more ego to deal with that."

PATIENT: "Perhaps I need a little more bravery to defy it."

ANALYST: "The little boy did not have enough ego to adapt himself

to the reality of superior power, and he is still rebelling impotently!"'

PATIENT: "It is due to my having submitted to my mother unwillingly in the hope that things would ease up and I would be able to get what I wanted. But I could not wait."

ANALYST: "*Before you can adapt yourself you will have to learn to endure the tension of frustrated gratification.*"

PATIENT: "I see now what it is—a matter of retaining the emotional reaction, and biding one's time until the occasion arises when it can be discharged. In other words, it is the question of one's capacity to endure frustration temporarily."

This is merely a hint of the early beginnings of the process of ego education. The process is the homologue of the upbringing of the patient for his real life as an adult in the community.

We must here leave further consideration of this subject and mention some important matters not peculiar to the terminal stage of analysis. There are two special difficulties in the practical application of analytical technique. One is the method of dealing with *defence-resistance*, and the other is matters connected with *counter-transference* and *counter-resistance*. Both these are of unique practical importance.

Defence-Resistance: To take the former first. Defence-resistance can be defined as everything which interferes with the operation of free association of thought and with the progress of analysis. Freud classified it under five groups. The first he called conventional *ego resistances*. These are usually pretty obvious to the analyst, but in dealing with them he must remember that repression is a means of preventing anxiety.

The second he called *transference resistance*. This must be interpreted by the analyst. Provided the transference stage is present, the analyst must deal with the resisted material which the patient is refusing to uncover by interpreting it, in spite of the patient's denials.

The third Freud designated as *gain resistance*. This is less important and represents the gains through illness. This is usually dissipated during the last phase of analysis.

The fourth are *super-ego resistances*, which, though they largely disappeared during the early stages, cannot be completely uncovered apart from the transference.

The fifth, or so-called *id resistances*, are a manifestation largely of the compulsion to repeat. They are analogous to instinct

activities and according to Freud indicate a phenomenon earlier in evolution than the pleasure principle, and are distinct from it. They require a great deal of working through and sometimes never entirely disappear. One is here reminded of the compulsive phenomenon of obsessional neurosis and the extraordinarily long time an analysis of this illness may require.

The analyst should remember that the patient is not purposely bringing up these resistances, although he may be their mouth-piece, but he is as much under their compulsion as he is under the compulsion of the forces which cause him to have symptoms. In general resistances are dealt with by interpretation, but not insistence. The order of activity for the analyst is first encouragement, second interpretation and then silence.

A number of alternative classifications for the phenomena of resistance have been vouchsafed. There is the clinical classification under which resistances are divided into (*a*) obvious resistances, such as those of lateness on the part of the patient, lag in getting to the couch, pauses and evasions, rejections of the analyst's remarks and so on, and (*b*) unobtrusive resistances. It is for the analyst to beware of these. He sometimes finds them only in retrospect as they frequently give no manifestation of their presence, not even protracted silences, the patient succeeding in covering up their existence. Sometimes they show themselves simply by a slowing of analytical progress, also by tendencies on the part of the patient to offer vicarious sacrifice, or to produce screen symbols, such for instance as genital symbols in place of anal objects which are really relevant to his conflict at the time.

Again, there is the classification under the *functional aspect of resistance*. Under this heading we have processes, such as projection, displacement, distortion, rationalisation, reversal, reaction-formation, counter-charge or screening and amnesia. Thirdly, there is *transference resistance*, which is essentially a resistance to the memory work which would show the affects being experienced as due to situations in infancy instead of due to the current situation. Fourthly, resistances have been mentioned in relation to *fixation points*. These sort of resistances are said to be shown largely by the patient's extra-analytical emotional reactions.

Counter-Transference: The second important difficulty encountered in analytical technique is that of counter-transference

and counter-resistance. For instance, the patient may project on to the analyst all qualities in himself which are repugnant to him. He, as it were, relieves himself of the disadvantage of recognising these qualities as his own by the simple, though paranoid, process of projecting them on to the analyst. In many cases his resulting accusations and disparagement and criticisms of the analyst may bear a chance modicum of truth and, naturally, on an emotional plane the analyst may not enjoy the experience. He will then have to do some analytical toilet of his own so that these, often very stimulating, accusations will no longer arouse his own emotional tendency to revulsion, however determinedly suppressed. He must never retaliate either actively or passively. For instance, he must beware of excessive interpretation emotionally motivated, as this may prove on the unconscious levels to be the equivalent of counter-attack or of sexual assault, if not of positive sadism. Conversely, excessive silence when help should be given, may be an outlet for the analyst's revenge tendency, or a reaction-formation against sadistic trends in himself. If the analyst is battling with such unrecognised affects within himself he will hardly be in a position to adapt his behaviour and remarks purely to the unconscious requirements of the patient. Further, the analyst must not, from unconscious omnipotent phantasies of his own, or such like, attempt to model the patient's ideology in accordance with any towards which he has a leaning.

Finally, it should be said that *intellectual* acceptance of psycho-analytical theories is of little or no value when it comes to the emotional world, which is the real province of the therapy and in which the changes have to be effected before anything approaching complete analysis can be claimed. Intellectual and theoretical structures break down utterly under the emotional forces of a transference or counter-transference situation.

The reader who has attempted to master the intricacies of psycho-analytical technique will probably be appalled at this seemingly impossibly ambitious programme. However difficult or impossible it may be to put this programme into practice in its entirety, and I must insist that I have here expounded only the mere outlines, there is probably no harm in the analyst having it before him as a counsel of perfection even if he has to forgo in most cases its full application, and modify it in accordance with practical expediency.

Occasionally major modifications have to be deliberately accepted and instituted, particularly when there are a large number of cases requiring attention and when the authorities in charge of hospitals and clinics are concerned to reduce their waiting lists and make room for other urgent sufferers. This is especially the case in time of war, and I shall therefore detail in the next chapter an account of one of my attempts to shorten the process in accordance with current requirements. A description of this attempt may, at the same time, show us some of the reasons why psycho-analysts favour, so far as possible, an application of their full protracted technique.

CHAPTER XXXI

A CASE SHOWING SOME IMPLICATIONS OF SHORT TREATMENT

Prologue: With so many doctors away in H.M. Forces during 1939-45 those left to do civilian duties in hospitals, clinics and private practices found themselves over-burdened with a press of patients, and, in the psychotherapeutic field, with ever-lengthening waiting lists of sufferers impatiently hoping to begin treatment before their nervous breakdown was complete. So much was this the case that one of the hospitals at which I worked made a definite ruling that *only* such patients as one could reasonably hope to cure by a short course of psychotherapy were to be considered for treatment. Accordingly I adapted myself to that attitude and in certain instances sacrificed the ambition of thoroughness and completeness in favour of the time-saving attempt to deal with symptom analysis only, avoiding those paths which lead to the deeper levels of the psyche in which nevertheless still lies the nucleus of every neurosis.

The case here described is an instance of such a treatment. I doubt whether there are many examples more favourable to the ideal of the psychotherapist whose mind is focused more on the practical issue of reducing long waiting lists than on the less obvious but equally practical psychopathology of neuroses. The question arises as to how much reality basis this ideal may have in psychopathology and as to how much of it may itself be a product of wishful thinking. Our conclusions may, I think, safely be left to the results of the study of this representative case.

Symptomatology: The patient is a big, manly-looking fellow in the forties with greying hair, a charming smile and attractive social manners. He is well educated, a doctor of philosophy. He has a wife and two children and was until recently happy in a fairly remunerative post.

All this is now changed. He says:

"Doctor, my sins have found me out. There is no excuse for my conduct."

He goes on to tell an extraordinary story completely out of keeping with the general impression he gives and with his educational attainments and responsible position. It reveals a deficient reality sense, particularly in the sphere of his private finances. He has for the past ten years become increasingly in debt, presumably through an inability to control his spendings. He has tried to deal with these debts in various impractical ways, sometimes by borrowing money from other friends to pay those who are becoming troublesome, but more frequently by wild excursions into gambling in the vain hope that he might in one sweep win back all his liabilities and clear the matter up in a day. These adventures have, of course, plunged him into further disaster, and have, during the last two or three years, led to the additional aberration of drinking bouts, clearly in the attempt to escape from an intolerable situation if only temporarily.

It was towards the middle of 1940 that things reached a climax. He obtained some bonus which had been expected and which he had promised to send to his wife to meet immediate liabilities. Instead, he cashed it himself and made another of his frantic bids to reach solvency in a day. He lost it all. Then he borrowed some money and made another bid and lost that as well. He says:

"That night I got drunk. I then absented myself from work, left London, and went round to various friends all over England borrowing money and trying to solve my problems by betting and not succeeding and then getting drunk. I went from bad to worse. I took to sleeping in air-raid shelters and railway waiting-rooms. The trouble was that I could not see my way back. I felt I should get the sack unless I could straighten things out by some lucky bid, and no luck came my way. I did not have any food at all. I walked into the hills and did not have the guts to destroy myself, as I had promised I would do if the next gambling bid did not win. Finally I was found by the police wandering and was brought back to London. My employers decided to give me another chance. A man took charge of my financial affairs and we paid off £300 of my debt in a year. That was in July 1940.

"It is difficult for me to give an explanation of all these things. I know I am awfully careless with money. If I am with people I buy drinks all round and splash it about. I always spend whatever I have got. I smoke far too much, nearly fifty cigarettes a

day. I tell myself I must stop it. I cannot afford it. And while I am thinking that, I find I have unconsciously lit another cigarette. I think the trouble is that I have never learned to control my spending. In some ways I am naturally a spendthrift . . . a sort of weakness of will. I never think where the next pound is coming from. I think there is a foolish streak of optimism in me, a feeling that God will provide. If I do start definitely controlling myself it comes to nothing for I suddenly spend the lot. I spend quite as freely and foolishly when I give presents as I do when I am spending it on myself. It may have something to do with the fact that I never had any money as a boy, or young man, until the age of nineteen when I joined the Army at the outbreak of the last war. That may have started me off, but there is no excuse for me now.

"The drinking part of it I think is just secondary to the worry and difficulties I get into through the spending and the debt. I can see no way out, and then I have to drink to drown the trouble.

"There is in me a curious resistance to doing things in my own interest. I neglect what would be to my personal advantage, but work like a nigger for something that holds no advantage for me. For instance, for the Home Guard, or as secretary for one of my societies. I could not tear myself away from the Home Guard because that was something one did for nothing. I think I gloried in neglecting my own interests. I have done thirty-six hours on end when it did not concern me, but have been overcome with laziness at the thought of doing an hour's work that would be to my own advantage.

The War Neurosis: So far the analytical material has given us no clue to the psychopathology of his aberrations of conduct. It is merely the anamnesis recorded at his first consultation while he sat up in the chair explaining why he had been sent for treatment. As the psychopathology was so obscure I suggested to him that we should have an interview on the following day in which he would be required to lie on the settee and record his free associations of thought.

Presently he remarks that he has always been subject to a recurrent nightmare—a nightmare which follows a prescribed pattern but has minor variations. The latest example of this occurred a few nights before and is as follows:

"My children, my wife and I are all asleep in our beds at

home. I hear a noise and go down to investigate. I find the front door, the back door or the window is open. At one of these somebody is breaking in. When I am about to take action—in a state of cold terror—I awake.

"The association of thought to that waking point, the cold terror, is: 'I am going into action . . . I am going to be killed.' But to tell you the truth, doctor, I would not be anything like so frightened in reality if I were going to be killed. There have been occasions in real life, during the last war, for instance going over the top under shell fire. I was not frightened like I am in the nightmare. Not at all. My feeling was 'if it comes it comes, I am ready for it'."

ANALYST: "*When did you start having these nightmares?*"

PATIENT: "I think it was only at about the age of twenty-five or so."

ANALYST: "*You said you went through the last war. What age were you when you finished with the last war?*"

PATIENT: "Twenty-three. I had not thought of that before. It seems such a long time for the last war to be having any effect upon my mind. . . . Yes, there *might* be something in that."

Suddenly he jumps up from the settee and says: "I wake up from the nightmare like this with the same gesture of defence. (I had not noticed it.) A cold sweat. . . . *Everything is coming* in that waking moment."

He is asked to lie down again and continue. He says: "Yes, there is something, but I cannot recall it . . . I cannot recall it. But there is something at the back of my mind. . . . Terror connected with a *blinding white light*." He gets up again and is evidently in a hurry to leave the analytical room.

Several other clues gradually accumulated, all suggesting more or less clearly some traumatic experience incurred during the last war. Admittedly it was most surprising that a case which came for treatment on account of recent and increasing aberrations of conduct should so early in analysis produce material suggesting a war neurosis of twenty-five years ago. But it became increasingly evident that the patient's emotions were most roused by material connected with war and its activities. For instance, he says:

"I admit that I have cheated my friends, but what I could not do, could never do, would be to cheat the national machine. I

feel guilty enough, but what makes me in a rage is not what I have done, but the thought of certain persons I know who slack at this time and draw huge salaries. What couldn't I do to them!

"I will never forget my emotions at the first Armistice:

'... If ye break faith with us who die,
We shall not sleep, though poppies grow in Flanders fields.'

The Vicar at X spoke it at the unveiling of the war memorial."

Here for the first time during his treatment the patient breaks down emotionally and cries.

He continues: "I took this as the guiding thing of my life, and I have always worked very hard with that in my mind. It was a very emotional day for me, Armistice Day, and then when this war came I felt 'that has done it'. We *were* young fools to think it was the war to end war."

(More weeping.)

"There are two things that disturb me very much: the thought of the fellows who died for nothing, and the kids in the present war. It hurts like hell when these kids of eighteen and nineteen join up perfectly happy. I hate to see them." (Sobbings.) "They are so young and so English."

Though there was no need to draw his attention to it at the time, these are obviously associations to his own experiences when he joined up in the last war at the age of nineteen. To the analyst it suggests the possibility that he may at that time have experienced a war trauma that inhibited his further emotional development, arresting him, as it were, at the developmental level of this age.

He continues: "Some of us boys went out without firing a shot—ordered to France. I can now see the faces in the lamp-light—rather scared, bright faces. It was winter. One boy I always remember." (Himself.) "He just didn't know what was happening to him. They all went out to France and they were all bumped off... just cannon fodder... and I can see these boys going now. I like them all so much." (Sobbings.)

Then, with violence: "I want a tommy-gun to kill the bastards who don't do any work. I am thinking all the time when I was invalided back from France and was musketry officer training recruits. I was twenty-two then. I had been to France. I had been in the war from the beginning. I got a

commission in March 1915 at the age of nineteen. I didn't have a bad war as far as fighting went. In France for eight months. I was sent back with dysentery. . . . I got it badly. . . . Went down to skin and bone and had many months' sick leave, until I recovered and was sent to this training battalion."

The patient lapses into silence. On enquiry he says: "I was just thinking why I was so muddled."

ANALYST: "*This blinding flash you spoke of at the end of your last session. Does that bring anything to your mind?"*

PATIENT: "Probably in France. I was in a trench-mortar battery in the line with different infantry regiments. It was a funny life. We had a billet just behind the line. We used to come in and out and relieve the men at the guns. Didn't have a bad time . . . I don't think so. Just very cold and muddy. . . . Jerry shelling us. . . . Lost a lot of men. . . . Lost a lot of officers. . . . Just shell fire. Nothing much happening. . . . Just silly trench warfare . . . fortress fighting. We would wander about no-man's-land and occasionally get bumped off. The worst thing we ever had was round about Loos."

ANALYST: "*Tell me about that.*"

PATIENT: "That was a bad three weeks. I remember two craters. A mound with a dimple at the top (*i.e.* a hole) at one end—and another mound. Thirteen officers in our bunch started that three weeks, and there was one unscratched at the end of it. We just got blown about . . . shell-fire casualties. Some were killed, some just blown up and shocked. I was one of the unlucky ones. Twenty-four hours in the front line and twenty-four hours back. I would just get comfortable when my orderly would call me. There was a period of ten days when I didn't get much sleep at all. One was not in too good fettle. Angry that I could not get near a Jerry. Acting as ordinary infantry carrying bombs up. We would come up on the road leading our men . . . under shell fire. I just went on and I got wounded in the end . . . just a little scratch. I do not know why the doctor sent me back. I went to him only to get a rag to put round my hand. The doctor ordered me out. I argued with him. They sent me to some convalescent camp for a week or ten days and then I re-joined."

ANALYST: "*What about this blinding flash?*"

PATIENT: "Up in the right sap—a trench—two great Bavarians and me and a sap running forward to no-man's-land. I was

ordered up there. It was a bad night."

ANALYST: "*What happened?*"

PATIENT: "All sorts of things happened. First we found a dead soldier—a Jerry slung on the top of our gun, and then it got pretty hot. It was a bit noisy . . . the batteries. We were ordered to fire and the men would not go to the gun position. I drew my gun and said if they would not go back to the gun I would shoot them. Not very nice. So they went back. I drew my revolver on them. They went back and did their stuff. Then I was ordered to go and look at the sap. I was leading. I was only a kid . . . just nosing round the traverses. I suddenly found the men had not come on. They had stayed behind. It was pretty grim. Jerry was giving us hell. Suddenly I met a couple of Bavarians round the corner—bumped into them. Phew! I was terrified. I got hold of him. It was so narrow that the other chap could not get hold of me. Neither of us could draw a weapon. We just started wrestling. Then the whole works went up in a blinding white flash. I think the one I was wrestling with was blown to pieces. Now I remember before that, in the light of a Verey flare, I suddenly saw two or three more Bavarians coming up. But this shell or trench mortar put paid to all that. When I woke up I was all in amongst his guts. I slipped in his guts. It was all blood and mess. There was not any trench left . . . just a hole. So I went back and found the other fellows waiting for me right down the trench. I cursed them. They made off up the sap."

This subaltern of nineteen years of age may have been obviously and conspicuously unbalanced during these events, and this may be the explanation for the apparently disloyal conduct of his men. Possibly they were more frightened of him than they were of Jerry.

"I do not remember much about it at all. Daylight was just breaking and I was messing about with a gun when that nose-cap came up and hit me on the back of the hand. It was the morning of that same day. I got into the dugout and was told to go to the doctor and get my hand wrapped up."

At the next session, which was his fifth, the patient said: "I really must tell you of the extraordinary experience I had when I came out of your consulting-room yesterday. I crossed the road and stood in front of Coutts' Bank. I felt quite dizzy. I stood for a moment or two and did not know where I was. I

thought, 'That taxi is the wrong shape, and what is the matter with that bus?' And then I thought, 'How do I get to Gray's Inn Road?'¹

"Now, doctor, I had no cause to go to Gray's Inn Road, or to think of it. My lodgings are in a totally different direction. The last time I was in Gray's Inn Road was in 1916. It followed up the story I had been telling you. After I had been wounded and had gone back to duty, within a week or two I got dysentery and that led to my being sent home to the Royal Free Hospital in Gray's Inn Road. The curious thing is I was thinking all that was the *present-day* reality. Finally I pulled myself together and got to the tube. I felt terribly tired. I was turning things over in my mind (probably he means in his stomach!) and then I found I was walking like an old man."

The patient then broke into a violent diatribe against politicians and others whom he says "have betrayed my generation and this one. I would call these years the Great Betrayal." (Consistently with the ideal of Short Treatment I refrained from interpreting this as hostility to the analyst.)

He continued: "I was quite all right until the beginning of this war. I was in a bit of debt, but my wife was looking after that part of it and we were quite happy together. In fact, we were pulling round, until the war came. It was *then* that I took to my gambling and drinking and made matters worse. I became very unsettled in my mind. The job I was doing did not seem to me worth doing in war-time. I felt I should be in the thick of it. That is why I overworked in the Home Guard and neglected my other duties.

"This reminds me of when I was wounded in 1916 after the white flash. I was sent to a convalescent camp where I slept solidly for three days and three nights. When I got up I was there for another week. It rained. We all just sat inside and gambled with cards—Vingt-et-Un—all the time from breakfast till after midnight, and drank as much whisky as we could get. *I won a lot of money.* Finally I went back from there to my crowd and into the line again. Almost immediately I got dysentery. Some of the men got diarrhoea, but my diarrhoea went on and on till I was reduced to skin and bone. In the end I was sent home to England with it."

¹ This indicates the exact degree of his insanity during the experiences he had just related to me.

At this point we may permit ourselves a few interesting reflections. We may recall that this man had come for treatment on account of a sort of financial diarrhoea and entanglement in the finances of his friends. This aberration of conduct seemed at first sight to be inconsistent with his character and altogether an unsolvable mystery. He has uncovered a traumatic war amnesia the content of which included entanglement in the "guts" of the enemy with whom he was wrestling for his life. He has now reminded us that immediately after this he gambled (and drank) from morning till night and won a lot of money. He has also called our attention to the fact that he subsequently suffered from continuous diarrhoea, officially called dysentery, but which we may now be justified in suspecting of having an hysterical origin. Incidentally, we should remember that this "uncontrolled spending" procured his release from the intolerable war situation. In this instance it has caused his release or suspension from his job. We may speculate as to what bearing all this may have had upon the conduct which, though not entirely quiescent up to the outbreak of war, received its chief impetus and exacerbation only after present hostilities commenced. Was it unconsciously to procure his "release" from an intolerable mental situation—a war within his mind? He had screened the awful amnesia of the sap by his hysterical diarrhoea, and subsequently years later by his financial spendings, debts and drink.

He continues: "I did not mind how much the first war hit me so long as one did not have to do it again. Then this war came. I knew we were unprepared. We sent a small force to meet the might of the German Army. We called them the heroes of Mons. It was *we* who killed them and now we send up boys half a dozen times a day in the Battle of Britain. *We* slaughter them. If we had done the things we ought to have done . . . It is the feeling of service that this war rouses in me—and the last one. . . . But I suppose I am focusing my attention on external things too much. I am tremendously keen on England and the future of mankind. I am the wrong way round, as miserable as sin about the war and about the future of mankind, and optimistic about my private affairs, thinking I will put things right by some wonderful bet."

The patient seems fairly good at recognising his displacement and projection mechanism, but this recognition has not so far

prevented a continuation of the process. He was asked to remember more about what put him in that extraordinary state when he left at the end of the last session.

He says: "It just happened, I suppose. We had been talking about the war . . . about that beastly time in the trenches having to do with the Bavarian, the poor devil—getting blown up and my getting mixed up with his innards. I have never told that to anybody. I would never have told you I was blown up. I wonder if I had forgotten it. It was just a bright white light that came into my mind after you had asked me when I first got those nightmares. When this war came on I wished I had gone with the others (the dead) instead of being with these fellows just fooling instead of getting on with the job. They used very big shells just at that time when I was hit. Banging off morning and night. I wonder why the doctor sent me down to the base hospital instead of back to the trenches. I did not want to go down to the hospital, I wanted to go on with my job, to keep on doing it. I remember him putting his hands on my shoulders and looking me in the eyes. He said, 'You have had enough for a bit, young man.' I told him not to be a bloody fool. Curious that he was not annoyed by a young subaltern talking like that." Then impatiently, "Pooh! It was not anything. I do not want to talk about it. Just a little set of trenches in front of a mining village. Aptly described in the usual bulletin 'nothing to report'. Just silly devils messing about in two sets of trenches . . . trench-mortar battery . . . little trench mortars we had . . . thoroughly unpleasant . . . nothing to matter. The men were not very happy there. It was tiring. The continual shelling and messing about at Jerry . . . who was only twenty yards away at certain points. They did not like it. Quite grown men did not like it. It was very noisy all the time and hard work. Not much rest or sleep. I slept for days when I got back."

ANALYST: "*What did the doctor see in your eyes?*"

PATIENT: "The doctor often has an understanding eye. I was out. Out on my feet. . . . I could not have stood much more. I would have done it. . . . I knew and he knew that I knew that he knew."

ANALYST: "*What had happened to you?*"

PATIENT: "Two-thirty to 3 A.M. the Bavarian and explosion. Then I was cleaning my guns. Mac had been hit the night before and therefore I could not lie down. Then, at 'Stand To'

at 6 A.M. I got wounded on the hand. I saw the doctor.... That was three and a half hours.

"Do you know I have not thought about that doctor for twenty years and now I can see his face. I slept for three days. In the next bed to me was an Army chaplain with a beard and I can see his face now."

Surprisingly enough the patient then mentions the financial muddle he is in and makes some reference to his wife and lapses into silence. On enquiry he says, "I was trying not to think about France and the trenches in front of Loos."

Up to this stage of treatment we had had only six or seven analytical sessions.

References to the war traumata recurred during subsequent sessions as follows: "I had told you, doctor, that I had never in reality been frightened like I was in my nightmare, that cold terror. I thought then I was speaking the truth, but I had forgotten. Since talking to you I have remembered that I was always very frightened in France really, but you could not let your men know that. I always wished I was a bit older in that war. Perhaps I would have been more cold-blooded about it."

ANALYST: "*Tell me about it.*"

"I remember sitting in a dug-out in 1916 full of noise and shell-bursts which had gone on for so long. I got more and more het-up. I remember suddenly thumping the table in a rage and shouting out 'For Christ's sake stop that bloody noise', and then looking up at the circle of faces and realising that definitely that was not the thing one did. I had betrayed a stress of feeling that one should not have betrayed. Just momentarily. I was ashamed of it. I did not want to die, but it was more the beastly noise and vibration all the time. One lived with the noise. It was unpleasant... if I had been a braver, stronger man... one lived with dead bodies and joked about it, but it was not the way you had been brought up... and then I had betrayed my feelings. I tried not to do that again. It was better to be alone. So I was alone as much as possible although I was scared—because I was scared, and being alone made me more scared. Always since then I have insisted upon being alone because I did not want them to know the sort of fellow I was. Because I was putting up a show all the time... that is how it seems to me now. The great thing was not to be found out. It astonished me when I went to France and found that I was not as brave as I thought

I was. Then that struggle in the sap. I was absolutely terrified just before that shell went up. I was more utterly frightened than I had ever been before. Just in that black split second . . . as bad every bit as the nightmare. And now I remember later when that bit of shell hit my hand I was really glad. I think that doctor sent me down because he saw I was just scared stiff.

"I was nineteen. At home adoring sisters and mother think you are a great fellow—they do not know what you really are—till you get the habit and have got to believe it yourself. So when you come to anything that makes it difficult for you to believe it, you avoid it instead of meeting it. Now I know that this—not facing up to things—was the reason for my drinking. I told myself I did not know why I drank, but now I know I would not face up to things. If you have a drink and a drink you feel like what you want to think you are: a hel great fellow—and so you get drunk again."

The "Cure": At the next session the patient continues: "I am beginning to think that all my past behaviour, drinking and gambling and getting into debt, is not necessary if I admit to myself 'I am a coward, I am a liar, a thief and so on'. I have got to do it that way, and so now it doesn't worry me. Now I feel that I will just accept it . . . and get some straightforward living again . . . and get my debts paid off. This is difficult, having no work to do, but in spite of these reality difficulties *now* I do not mind—*now* I can do it."

It appeared from this material that the patient is beginning to feel that a recuperative process has set in—that he is on the road to cure. This impression is confirmed by the material produced at subsequent sessions.

He walks eagerly into the consulting-room and immediately relaxes. In spite of a rather protracted silence his expression is one of peace and contentment.

On enquiry he says: "Well, I was thinking that I am chiefly surprised. I am surprised that I feel a contentment all the time. I am surprised to find myself . . . I cannot say happy . . . yet content to jog along. Then it occurs to me that *I should not* be feeling like this, living as I am away from my family. Yet I am not able to shake myself out of this condition of bovine contentment. It is very unlike me . . . usually I am on the go all the time. But this is a very pleasant state to be in. In any case I cannot shake myself out of it if I try . . . and I do not want to

try . . . I am quite happy to wait for whatever comes along. My debts I seem to be content to leave to some future occasion. And my difficult position . . . I wish of course they would get it settled up one way or another. . . .

"I have not much to talk about really. The war does not seem to worry me at all . . . as it used to do. I have just a feeling in the upshot of the war that I never previously had—not since the beginning of the war. Why should I not have any wants? I do not want to go to the pub or for amusement or anything. I simply cannot understand why I am in this contented state."

ANALYST: "*Any passing theories?*"

PATIENT: "No, I have not thought of anything at all. I am astonished. I am surprised, but not terrifically so—just calmly surprised. You see I have always felt something must be done about it. Things *used* to rouse me to the thought that something must be done about them immediately. Now I am merely surprised that I no longer feel that desperate need to get up and do something."

ANALYST: "*Why?*"

PATIENT: "I cannot answer your question at all. It simply is so."

After a considerable quantity of similar material the patient again lapses into a contented silence completely without any trace of anxiety. On enquiry he says:

"It is very pleasant to be just lying here."

It is evident that he has given himself up to the transference, but with a view to as short a treatment as possible I had decided to avoid any transference interpretations. Nevertheless it was felt that the pleasure in just lying here could hardly be left unmolested, so presently the patient was again asked to say what he was thinking.

He says: "I was nearly going to sleep. From this half-sleepy state I cannot bring anything up for you except one dream of last week after I had been here. Since then I have not dreamt. But to show you how contented I am I will tell you that I cannot remember that dream at all. However, I wrote it down at the time and if you want it I will find it."

I expressed a desire to hear it and the patient with some reluctance bestirred himself to find the slip of paper. This is what he read out:

"You and I were in an ordinary doctor's consulting-room. I

was dressing after a physical examination. You said to me: 'It is quite a simple case. You have got a lesion of the spine. There is a growth of bone on the outside of the second dorsal vertebra between the shoulder blades. I will soon cut that off when I get you on the table, and then you will soon be all right.'

(End of dream.)

"I awoke at that stage and I can remember now that I smiled happily to myself. I punched up the pillow and *fixed it in a hard lump between my neck and shoulder* and went off to sleep again.

"I am surprised now that I had completely forgotten that dream because I dreamt it three times."

All the patient would say about this dream was that it confirmed his impression that he was now cured and had nothing further to worry about. On being pressed to do association of thought to the dream, he said that the growth of bone on his back was the load of debt and worry and disgrace which he had been carrying all these years. It had now dropped from him or been taken from him by me and therefore he smiled so happily on awakening and promptly dropped into this contented sleep.

At the next session he continued to luxuriate in a feeling of well-being, at the same time producing no analytical material whatsoever. These are his remarks:

"It is puzzling to know why this change has taken place. What have you done to make me feel like this? I have rummaged my mind without effect. But that there is such a change in outlook is very definitely the case and most certainly I do not want to change it. I am quite satisfied to come here and lie on this settee. But I expect that very soon I shall become a bit impatient to get on with things. I am becoming increasingly convinced that I am quite cured, and that is why I have nothing more to talk about. Of course that may make it all the more puzzling that I am still eager to come here. I still like coming.

"I am still cogitating upon my changed outlook . . . although I know that I am well. For instance, walking along from here yesterday I found myself arguing with myself as to whether I should have a drink or not. My impulse was to go and have a glass of beer, but something in me said, 'You dare not, you simply dare not; you know if you have a drink you will have another and when you go home from work you will start drinking again'. Finally I went and had just one drink and I *did not want any more*, and in the evening I had no impulse to have

another drink. That is to say there was no conscious effort to restrain myself, it was just a normal fellow having a drink because he wanted it. That has not been the case for some years, especially for the past two years."

ANALYST: "What would have been the case?"

PATIENT: "I would have had as much as I could afford until I was desperately late for lunch and that would have left me with a craving for it when the pubs opened again, and so I would have gone on until the next day drinking and drinking. Since they took over my finances they have not allowed me any money to drink with and I had promised not to enter a pub. So you can see why I was interested in my perfectly normal behaviour. I did not feel I was doing anything I should not do. I felt it was the normal thing to go and quench my thirst.

"Further to confirm the reality of my changed condition I can tell you of another curious experience I had yesterday afternoon. *I wanted to cuddle a baby of twelve months.* That is extraordinary for me because I do not like babies—not until they can walk and talk. I think I have always disliked babies because my mother always made a terrific fuss of them. She used to say 'Oh the little darling! Isn't it sweet?' when it looked like a boiled lobster and smelt. I disliked it in my mother and I disliked the babies that she was fussing over, and yet yesterday afternoon I definitely liked the baby and wanted to get hold of it. I cannot explain why this dislike has departed quickly like this."

A few sessions later he remarked that he was liking people a good deal more. He said: "It is not from outside, it springs naturally from inside. It flows . . . it is in all of me . . . a sort of oneness with the world I live in . . . very pleasant.

"It is a real change from getting hot and bothered and wanting to go out and string people up on lamp-posts because the social fabric is not as it should be. Now I do not mind what other people do. It is all part of the change in me. When did I start not minding what other people did? It was that week when you gave me five sessions—that is the week before last. I feel that everything is now coming all right, that I shall have nothing further to bother about for evermore, and, as you know, this is not a new idea that has just happened. I have been feeling like this for several sessions now and in between the times of coming to see you as well. To my mind it is a complete and permanent cure. I feel I want to recite 'The Ship that Found Herself', and

that I shall always be smiling and happy henceforward.

"But now the thought comes to me that I should not have told you, that I am reluctant to tell you, in case you say there is no further need to attend. Strangely enough, for some reason I cannot understand, I very much appreciate coming and having these little talks with you. I would miss them very much indeed. In fact, I do not think I could yet reconcile myself to the idea of giving them up. Once or twice I have been a little concerned lest the idea should occur to you. This thought is the only thing that has occasioned me the slightest anxiety since I felt so much better. Anyhow, be that as it may, there is no doubt that I have found myself and am cured."

It seems from this material that the patient has one symptom left and one only, and that is a need to attend and see his analyst. It might be argued that this corresponds to a very natural human tendency common to all persons in normal health—everybody must have someone, relative or friend, to whom he can go for companionship and intimate discussion; there is nothing pathological about it. All we need now do is to transfer this friendship to some person other than the analyst, someone such as wife or friend, and, as the patient assures us, "all is well for evermore".

So perhaps we may congratulate ourselves that here, in the course of a mere dozen and a half sessions, we have arrived at a position which can confidently be regarded as cure, and we may pause for a moment to reflect how this has come about.

It seems that in the unearthing of this war trauma, and in the bringing to consciousness of the content of the amnesia associated with it, we have found an explanation for the patient's hitherto incomprehensible delinquency. The operation has been completely successful. The nucleus of this evil growth has been eradicated. The wound is healed, all our problems are solved, and it remains only to bid the patient goodbye.

The Relapse: Unfortunately for our prognostications and for those of the patient, though his dream of the operation suggested to him that cure was complete, the amputated tumour, *like life itself*, speedily showed signs of malignancy. Within a few sessions it was growing again.

The patient says: "Last time, I went out of here reciting 'The Ship that Found Herself', and smiling away to myself, but in

the meantime I have realised that this is not quite true because I have had for the first time since my treatment started a mood of depression. Also I have felt truculent and rebellious.

"This morning I resented the thought of coming here. I resented the life I am living with all these people controlling my money affairs and so on. I had the impulse to chuck the whole of this treatment and just go off in my own sweet way . . . and enjoy myself. All that restrained me was an impulse of fear. I thought of not having enough to eat and nowhere to sleep. I do not know any reason for this sudden change of mood. All I know is that I am impatient with life."

And thus we are introduced, whether we like it or not, to that period of early life when the tumour first started to grow, when such instincts as were not gratifying to the parents began to develop and initiated the beginnings of rebellion against parental desires and authority.

In the light of these new events it is high time that we took stock of the situation and obtained a truer and fuller insight into what has been happening in the patient's mind—into the deeper psychopathology of his illness, and particularly into the psychopathology of the processes that brought about his striking illusion of cure.

The improvement shown by the patient at that happy stage of analysis when cure seemed assured, though seemingly due to the bringing to consciousness of the repressed traumatic affects belonging to his war experience of twenty-five years ago, are really due to quite another cause.

It is this: the repressed war affects bound to the repressed amnesic experiences have been released from repression. With them a store of repressed affective energy has been released. *This has attached itself to his image of the analyst.* The initial positive transference to the analyst has been reinforced. In other words he has found a good-parent imago. Therefore he can regress to infancy, happy in the feeling that all is well. That is to say without any anxiety and without any need to deal with anxiety by drinking and gambling, and without any need to dramatise it by getting into debt and trouble. He is an infant leaning contentedly upon the all-powerful imago.

But, and this is the danger of the situation, he is not really an infant, and unlike the infant he does this only by the sacrifice of genital sexuality.

Admittedly at a later stage of development the growing child would similarly be asked to sacrifice or repress tendencies to sexual development on a genital plane. This is where rebellion begins. Hitherto in this transference situation we had not arrived at that stage. But if, with the patient and in accordance with the inadequacy of his own personal analysis, the analyst is content to luxuriate in this self-appraising situation, he is courting danger. He may, of course, dismiss the patient, but in that case the only difference is that sooner or later the danger will develop outside instead of inside the analysis. It will be called one of these unaccountable relapses. The danger is due to the fact that this improvement incorporated in the parent-son situation is maintained only by a repression of genital sexuality. *All the unconscious hostile attitudes of the child-parent relationship which form the basis of the whole neurotic structure (and which are responsible for the conflict from which emerge both anxiety and the rebellion) have not yet been even approached.*

No doubt if the regular analytical attendances continued uninterrupted the patient would repeat his original development, progressing from the contentment of babyhood (cf. his desire to cuddle a baby of twelve months old—*himself*) to the ambivalence of infancy with its Oedipus conflict between castration and rebellion. The stage we had reached was that in which, having obtained a strong positive transference, he solved all his problems by a regression to earliest babyhood. Nevertheless, in keeping with the ideal of short analysis I here proposed to let him go simply by the expedient of not encouraging further development, by not bringing out his negative transference and avoiding the need to analyse his as yet unexpressed hostility.

That these theoretical considerations are justified is borne out by the material the patient began to produce before he could be persuaded to discontinue analysis.

It is here noteworthy that although he was saying little or nothing this patient was obviously quite happy to attend for his sessions as often as possible and to lie on the settee in blissful contentment, his expression seeming reminiscent of the happy baby put out in a pram in the sun.

In sharp contrast to this is the usual analytical situation of a speechless patient showing every sign of anxiety, and, in spite of a relatively early stage of analysis, insisting that treatment is at an end and demanding to be released from attendance. This

was the position of the patient described in my paper on "Analysis of a War Neurosis".¹ This is a sure indication of developing negative transference. Hostility is breaking through repression and calling for analysis. But the hostile patient makes every excuse or rationalisation to *leave* the analyst, for his presence is a source of anxiety.

In this case on the other hand such a stage had not yet been reached. The degree of regression was to an age of infancy when all was blissful before frustrations or conflicts arose. He was in no hurry to leave it.

Nevertheless, whether we like it or not, life, like time, marches on. Instincts, however disturbing to the parents' need to have and keep a dependent baby, come into being and develop according to their prescribed phylogenetic pattern. Thus conflict, analogous to that of the maturing bull with its progenitor, is the order of life. The offspring, if he is to be a man, sooner or later shows truculence and rebellion.

In association to the affect of truculence and rebellion the patient says: "I have always been a rebel. It is a natural rebellion."

Suddenly he cries aloud: "Leave me alone." I ask him: "Is that remark addressed to me?"

He says: "No, it is addressed to my parents in adolescence.

"The visual image was the house where we lived for years before the last war when I was fifteen. I was living a double life, paying lip service to a religious life that I did not believe in. My father was the mayor and a deacon of the Church. In the small community we lived in his family were the centre of criticism. We had to live up to a false standard. For instance all alcohol was taboo. There was a pretence going on all the time . . . that childhood . . . almost unbelievable . . . the narrow rigid conduct . . . people would die rather than take a drop of brandy. That imposed an artificiality on my life. One tended to live outwardly according to certain artificial standards, but the great thing was not to be found out. When the religious beliefs go I do not know what you can substitute for them. Perhaps it was because they had gone that I was not very happy . . . in an insecure situation. (He had lost the Almighty Father, but had not relaxed his super-ego.) It astonished me when I went to France to find that I was not as brave as I thought I was. At

¹ *Brit. J. Med. Psychol.* vol. 19, part 2, 1942, and *War in the Mind*, chap. xxiii.

home I had managed, the lip service fairly well. My desire was forbidden fruit and wild oats, and as soon as I got into the Army I was having a jolly time doing all the things I was supposed not to do. Drinking chiefly. Freedom from restraint. I could even talk to a girl without arousing comment. All this had been impossible at home. I naturally get my back up when I am asked to do something."

ANALYST: "*Free association?*"

PATIENT: "I won't. Why should I? I often felt like that when I was a boy. The association is mother—an early period of my life at the age of twelve, or rather ten, a sailor's suit with a blasted *blouse* which was much too young for me and I hated it very much. I am walking from Sunday school with my mother. It had been bought and cost money which could not be thrown away.

"As a Boy Scout mother sent me out with heavy woollen combinations under my shorts. That was at thirteen or fourteen. At one period of my life I had to wear small women's combinations with their insets at the breasts. My God! That did annoy me, but there was no way out. I was absolutely mastered. I was in a frightful temper . . . high dudgeon and bad temper. I refused to come out. . . . But I was frightened of my mother. I was pushing the bed towards the door to barricade myself in. I was very angry indeed. Then comes the association that whenever you did anything you ought not to do, you scored a point. You deliberately rolled up the legs of the combinations and got your knees wet to get rheumatism."

At this point I reminded the patient that his truculence was about coming here to his analysis. "*Mother was making you wear these female garments. You felt that your mother was preventing you from being a man. What am I doing to you?*"

PATIENT: "You are making me talk about myself. It is not a habit of mine. Before coming here my double life was a secret to me. Then comes the thought that I do not want to be 'harmonised'. I want to go on being bad."

ANALYST: "*It sounds as though I am preventing you from 'being bad' just as mother was preventing you from being a man.*"

PATIENT: "Yes, that is it. That is what I am rebelling against. I insist upon being bad. I will not be harmonised."

ANALYST: "*What does 'harmonised' mean?*"

PATIENT: "What mother wanted me to be and what I refused

to be. There would be nothing in life worth living for. It seems it was only worth living to be bad."

ANALYST: "What is this badness you insist upon keeping?"

PATIENT: "Oh, that I don't know. The only thing that makes life worth living. But I must say it has been responsible for all my troubles . . . all the burdens I have had to bear these later years."

ANALYST: "Is that the thing I cut off in the dream?"

PATIENT: "Yes, that is it, and I thought it was a cure, but I don't want your bloody cure. I will stay as I am, thank you very much all the same. I am going to keep the bad thing just the same."

ANALYST: "And not be mother's little boy?"

PATIENT: "No, blast you!"

"When you said that 'mother's little boy' stuff it caused me a flash of resentment."

ANALYST: "Well, what was it I did in the dream?"

PATIENT: "You cut off the bad thing. And yet in the dream I cannot understand why I let you do it. Why I seemed so utterly contented and even when I awoke still felt the contentment—rolled up that pillow into a ball and tucked it firmly between my neck and shoulder and immediately went to sleep like a newborn baby. I do this in real life. When I sleep I like the pillow under my shoulder . . . I snuggle into my pillow.

"I suppose I had found something else instead of my badness which seemed to me to be more than a compensation for it."

(Silence.)

"I am thinking that I am in chapel with my mother. I used to sleep by her side and put my shoulder under her forearm with my head on her forearm so that her forearm would press between my neck and shoulder and *that is exactly where I always put my pillow now*. I must have been very small. I still do it . . . I knock hell out of my pillow, punch it up into a hard lump. Although I am worried about the disgraceful state I leave my pillow in, especially when I am not at home, yet I have definitely been unable to get to sleep without it.

"Now I can smell the smell of kid gloves . . . I feel that I am playing with the three ribs of mother's glove . . .

"When did I start knocking hell out of my pillow? Only during the last ten years. It seemed connected with the time when I started getting properly messed up and worried to death. *I sup-*

pose my badness had led me into trouble so I had it cut off and went back to the pillow."

ANALYST: "Would it be about the same time that you started to need a little consolation in drink also?"

PATIENT: "Yes. What came into my head then was simply food . . . the sandwich tin we used to have when I was three or four years of age. I think I must have been quite hungry often at that time—three or four. The lump on my spine in the dream was between the shoulder blades—four or five inches below the base of the neck. Perhaps it is the imagery of too much on my back—a load on my back—that makes me different from my fellow men. Most of them regarded me as a criminal when I was given my second chance. Having to have the deformity removed makes me think of the deformity of difference and bad conscience, having to have that removed. That is the thing that makes me different from my fellow men—a feeling that strangers in the street would feel I was not a decent honest person.

"What an awful load of guilt-feeling I have carried until I came to you for this treatment. And now it seems I am fed-up with you and this treatment and with these people who are wanting to remove my load of debt. I have felt rebellious and resentful . . . as though you had taken something good away from me although I call it something bad. I suppose the feeling is that I cannot go on for ever with mother's forearm tucked between my neck and shoulder and feeling in a blissful state of health. There is something else stirring in me . . . something which made me go out and get drunk and get into debt—the lump has grown again. But I must say this for myself: that with all my badness I have never gone out womanising or whoring as it is sometimes called. I have always been completely loyal and faithful to my wife. We have been parted a great deal, especially since this war started. It was while she was away that I had that bad bout of drinking and gambling and borrowing money and even wandering off until I was found and arrested. But I was not seeking any sexual adventure. It is only drink and the excitement of gambling."

ANALYST: "So I see that if the lump that will grow in spite of mother's attempts to stop manhood is not the phallus, it is nevertheless a rebellion against mother and her successors—a rebellion that makes you feel like a man. You are not sufficiently disloyal to seek another woman

but you compromise by seeking drink and other liberties. Or perhaps the same liberties are compromises between the primitive excitement (sexuality) and the substituted or cultural ones connected with money. You get the excitement, but not sexually. Early in your analysis you were so pleased at having found mother again that you readily gave up your lump of badness—our manhood rebellion—and came back to lie on my settee and smiled blissfully as you did in church when you nestled against your mother. But it could not last for ever; babyhood cannot be a perpetual state. So latterly you have been repeating your rebellion against mother which was concurrent with the growth of your sexual impulse."

Growing Up: At the next session the patient brought me a dream. He explained that it was different from his typical nightmare which he had not dreamt at all since the early days of his treatment, and that was very surprising, as for ten years or more it has recurred pretty often. But this dream of the other night suggested that he was going to approach the nightmare dream. He says: "But it was different in some way. I was in that room in the house at Norwich where we lived when I was seven or eight. It had french windows overlooking the garden. The maid was there just as she used to be. I went through the house as I did in the nightmare dream, but not in a state of terror. There was no fear. Only my memory would say that something (the nightmare) was going to happen and I had to go round the house to see that it would not. The scene disappeared completely and I seemed to sleep on without dreaming any more."

In association he says: "I now say that I might be going to dream the nightmare. I keep on resisting. Finally I am driven to the last attic. Then comes the blinding flash and I am waking up in acute terror.

"We connected that with the explosion in that sap which knocked me unconscious that dreadful mad night."

ANALYST: "*What is new in this particular dream?*"

PATIENT: "That room at Norwich with the french windows. But I cannot say it is new. It is just as familiar and vivid as if I were in it now. And now I come to remember it . . . it was in that room. We had just moved into that house . . . that was the last time she did it."

ANALYST: "*Did what?*"

PATIENT: "Made me lie on top of her. It was the same maid. She had interfered with me at the previous house. Though I must confess, doctor, that I had begun to find it very pleasurable.

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And what is more it was something that mother did not interfere with—didn't know anything about—at least not until that occasion at Norwich. Something must have happened then. I don't know what or how, but it was after that that I seem to remember a terrible cross-examination that took place from my mother. It is the horror of that that I remember. I think I am devil-driven to repeat the pleasures that the maid taught me. But still I am loyal to my wife—I do it all by drinking. What the maid taught me was the pleasures that could be had by defying mother behind her back. If only she had not found me out I should not have been given this terrible feeling and this dreadful impulse to rebel. I think it was mother's talk to me that imparted a twist in my mind. There is a terror there that should not be there. Yes, it was wrongly handled in childhood between the two of them. Nevertheless, my memory tells me that what the maid drew out was natural feelings. The thing that happened to the little child was quite a pleasant thing and I felt it should be a pleasant experience in its life later on, and yet when it was found out by mother this very pleasant thing became the most awful horror and squalor and filth. It somehow caused a complete bewilderment in my mind. And then comes the determination to do this thing in spite of prohibition."

ANALYST: "To make it pleasant again?"

PATIENT: "Yes, quite. It would be such a fundamental gain. The feeling is that they want to castrate me instead of letting me be a boy, and I will be *more* than a boy . . . *a devil*. And then something in me would not let me be disloyal to my wife and so I do it in a department that is not her department, I do it not by sexuality, but by drinking and gambling. That is the way I live. There is some conflict with money castrating me at the back of it all. I liked mother very much. I wanted to be on her side. Yet to achieve that this other thing had to be cut out completely; and so at one moment I have it cut out completely, as for instance by you in the operation dream, and then the next moment I want it back and want to cut you out completely. It seems a conflict between what mother would call good and bad, but something in me is calling the bad good because it feels good. It is a conflict between these two. It seems to me that that must have happened in some way before the sap."

ANALYST: "Why did this always happen in an attic?"

PATIENT: "Perhaps she took me there in the afternoon when

the others were out, but I don't think so. In the dream the attic was where I took my last stand. I had been pushed up, higher and higher, by the intruders. There was no further retreat. In the attic it was do or die . . . and apparently I died.

"At first it was nice, but then I would start to resist it. I would get frightened when my resistance seemed to be breaking down . . . and then suddenly something would happen. I think I went unconscious.

"Still it seems I did not resist the beginning of the sexual experience. Even if the end part was a nightmare I went on having that nightmare again and again, perhaps welcoming it until it was too late to withdraw. I told you I have only had it during the past ten years, but I was at Norwich at seven or eight years of age—and I feel I had it then. In the final part of the nightmare, when I have been driven to the attic, 'they' come in; the terror is indescribable; there is a blinding white flash and I awake and start up in panic.

"It may be that the war experience and the blinding flash revived it all years after it had become quiescent."

Psychopathology: A certain amount of the psychopathology of this case has been dealt with by the patient and myself in the course of discussing the analytical material, but it will clarify the matter and make it more complete if we briefly review what it has to teach us.

To begin with, we detect in this apparently mature man bouts of irresponsible, impulsive and delinquent behaviour, so out of keeping with his general social character as to suggest the manifestation of an unconscious or dissociated part of his personality. He himself has called it his "Jekyll and Hyde" personality.

Guided by the clue of the terror of his recurrent nightmare and particularly of the phenomenon of the blinding white flash, we are speedily led to the uncovering of an unsuspected war neurosis of twenty-five years ago. The filling-up of this amnesia seems to offer an immediate, at least partial, solution to the otherwise incomprehensible symptomatology, and an explanation of its exacerbation at the outbreak of the present hostilities.

In fact, these revelations are welcomed by the patient, as a complete explanation of everything that has transpired; and, in view of the change which took place in his affective disposition,

he seizes upon the illusion that a complete cure has been effected. This cure he would ascribe to the analytical material produced in consciousness. But from the nature of his emotional attitude it seems to the analyst that it is in fact due to the situation of positive transference, the consequent surrender of himself to the parent-figure and regression to a very early stage of infancy.

The evidences in favour of this theory are mostly silent ones. He is content to lie on the analytical settee and do nothing. Only a baby can lie contentedly and do nothing, "perfectly happy" to wait for whatever comes along. This is the affective state when one has not yet learnt to walk—a smiling baby basking in the sunshine of mother's perfect love.

If confirmation were needed for this theoretical structure the patient provides it in his surprising discovery that, unlike his previous self, he has a strong desire to cuddle a baby one year of age. He could not have told the analyst more plainly that *he* is one year of age and loves himself—as we all do at the auto-erotic level before the capacity for object-love has developed (primary narcissism).

Further, he tells us that at this period the outer world no longer exists for him affectively. He says: "It is a real change from getting hot and bothered and wanting to go out and string people up on lamp-posts. . . . Now I do not mind what other people do. It is all part of the change in me. . . ."

This is the stage of "cure".

As our object in this particular instance is to avoid lengthy analysis even at the expense of completeness, an attempt was made to ignore the transference and to eschew any transference interpretations in the hope that the patient might then himself cease treatment, though not before he had gained some superficial degree of improvement. This was hoped for despite the knowledge that even early or apparent improvement is not due so much to the uncovering of an amnesia as to the resulting positive transference; and secondly, despite the fact that the premature breaking-off of treatment by the patient is only likely to come about, or to be assented to by him, when he has reached a stage of unexpressed negative transference. Of course it is then the analyst's duty to encourage him to express the hostility and hatred which form the basis of the whole neurotic structure rather than to dismiss him with these still lodged within his emotional system. Many a person having had such a superficial

"analysis" may well wonder why he or she is still ill. *The libido cannot successfully achieve its full orgastic discharge in the presence of its enemy the hostile world which is the projection of one's own unanalysed hatred, or of one's conflict between id and super-ego.*

Thus the essence of successful analysis, namely, the exposure and analysis of transference resistance, is not even attempted. A state of unadulterated positive transference may be regarded as a sure sign that analysis proper (*i.e.* the attempt to deprive the id of its treasured symptoms, its conflict with the super-ego and ego) has not yet begun, for the beginning of this, like the parent's original bowel education, would surely lead to some resistance and tax the strength of positive relationship. Directly the uncovering of any resisted material is even attempted negative transference begins, action, at least within the psyche, becomes necessary, action which derives its energy from the negative. There is no more time for "basking"; growing pains set in, and up comes aggression.

Despite these considerations the ideal of short treatment was adhered to. Obviously it is not a cure merely to achieve an emotional regression to earliest infancy and then to leave the patient to struggle with his inevitable subsequent development. Those who understand analysis adequately could no more be content to adopt such an attitude than an understanding parent could leave her baby of a few months to grow up by itself as best it could. Admittedly the pattern for future development has been previously laid down, but it might be contended that the baby also has phylogenetically a prescribed pattern laid down within its germ cell.

However, further development proceeds apace without awaiting our abandonment. Following his dream of "cure", no sooner are the "bad things" (the growth) removed than the child snuggles its shoulder into the mother (analyst) and is not to be persuaded to let her go until it has again reached a genital level of development. (There may already be indications of this in the violence of "knocking hell" out of his pillow.) With this development his relationship to the analyst (mother) changes. He begins to resent her tendency (the analyst's supposed tendency) to keep him infantile and phallusless. Before this stage it was noteworthy that he did not wish to leave the parent. He had no desire to break off treatment although he could find no material with which to fill the time. At that point his silence is

not negative, it is positive. He wants the mother imago in the shape of the analyst as nothing has yet developed to come in conflict with it.

But now we see this development beginning. It is shown affectively by his feeling of truculence; or, if this rebellious impulse is suppressed, his feeling of depression. Something is trying to grow, and something else—the mother imago—is opposing its growth.

If health is to be achieved, nature's libidinal impulse must win. Sexuality must grow and mother must be pushed aside. In so far as this is achieved health will result. In so far as this development is stunted or twisted by the mother forces, in so far will orgastic potency be impaired and ill-health result.

The patient treats us to a brief historical review of this struggle as it took place in the early years of his development. The sailor suit, like the combinations, represents mother's determination to keep him emasculated. His rebellion against these represents his inner urge to be a man. So much so was this the case that rebellion came for him to symbolise manhood and potency, almost on its own account. The achievement of these instinctual aims had unfortunately at an early age become linked up with the idea that they could only be gained by deceit. Perhaps the outstanding contribution to this was his infantile association with the maid whilst relying upon the deceiving of mother.

If the relationship to the parent favours libidinal development we have the nuclear pattern of loyalty, and perhaps righteousness; if libidinal development is experienced only by deception or "destruction" of the parent we have the nuclear pattern of anxiety, delinquency and crime.

In the absence of a longer analysis it is difficult to judge the extent to which this patient's early sexual experience may have been the causal factor of his hysterical disposition. One feels that if the white flash represents pre-pubertile or infantile orgastic experience the effects must have been very considerable indeed. Before the conflict of sexuality with the mother imago or the super-ego, there would surely be even deeper and more fundamental conflict and acute anxiety within the id itself. For we have evidence that orgastic experiences at a very early age are commonly accompanied by the most acute anxiety; so that instead of healthful orgastic relief, fear may temporarily overwhelm the ego and even produce momentary unconsciousness.

Unfortunately, to clarify the matter in this particular case a deeper analysis would have to be conducted, but in the light of past experience I cannot avoid the speculation that this patient's psychosexual pattern, his war neurosis, his anxiety and his delinquency are all attributable to some such early sexual experiences as their nuclear source.

For instance, within his nightmare itself we see represented not only the invaders of the house, suggesting primitive aggression, or latent phallic sexuality, but also the defender being himself attacked and retreating whilst defending himself without avail. Moreover, it is with the latter and not the former that he identifies himself. His masculinity is repressed, dissociated and projected while his feminine component unsuccessfully struggles against this larger and more powerful sexual aggressor. The struggle ends with the blinding flash and the momentary unconsciousness. Is all this a re-living of his emotional experiences during the seduction by the maid—an emotional pattern which was later experienced in adult life in his struggle with the Bavarian?

The relationship of the nightmare to this latter experience emerges early in analysis, but its effectiveness in causing mental illness may lie in its correspondence with the earlier and more nuclear pattern already laid down. Conflict, whether between libido and fear or between libido and super-ego, undoubtedly impaired his potency, for both within the nightmare and within his war neurosis we may detect anxiety associated with the defence of his femininity or homosexual element.

May it not have been that in the course of his seduction by the maid he was in the rôle of a female being attacked by the maid's masculine sexuality (cf. the brigands entering the house)? He resists and struggles to defend himself against his mounting libido. But his resistance is of no avail, the maid's masturbation of him continues. Finally he is forced back into the attic, the highest point of erection, tumescence and sexual excitement. There the white flash or orgasm takes place and he momentarily loses consciousness.

We might expect that subsequently throughout his life acute anxiety would develop whenever he is attacked by masculine sexuality or by a male. (He tells me that he cannot bear a male to sit next to him or to bend over him.) He would again become his feminine component, defenceless like the house with the

open door or window and urgently requiring the mobilisation of his defences—defences which nevertheless his early sexual experiences had taught him were of no avail. Orgasm (or death) is inevitable.

It may prove a plausible hypothesis that a tendency to morbid anxiety, such as that responsible for war neuroses, is invariably due to this feminine component within the man, and, on account of its libidinal attraction, this feeling of the need for defence against it, and the fear of the futility of defence. In other words, fear may not be so much the ego fearing death as the ego fearing orgasm or orgastic castration.

The further question may arise as to whether the most primitive id may not itself fear a quantity of stimulation which it is incapable of holding—for instance the new-born baby's fear of a loud noise. In addition, we should remember that quantitatively stimulation can be converted into libido *or* anxiety or both.

To return to our patient. We may suppose that it was not so much the Bavarian or even the shell-burst which sent him mad with fear and caused this war neurosis. It might well be the fact that the feminine component of his sexuality had been so much stimulated in childhood that he had cause to fear its ability to overwhelm his resistances. The Bavarian and other enemies might then be merely symbols of the maid, and the white flash the orgasm. As such they would be precipitating factors, not causal factors of his neurosis.

Perhaps as a result of the events in childhood this very manly-looking patient, as his nightmare suggests, had had the masculine side of his development inhibited in favour of his femininity with a consequent impairment of potency. I would suggest also that a man so much in love with his wife who permits himself for such a long period to live apart from her is probably thereby masking some degree of genital impotence. On the other hand we commonly find that a marked degree of genital inadequacy causes a man to cling to his wife—much as an infant clings to its mother, and to feel anxiety if even for one moment he does not know where she is. At the same time if a man's wife unconsciously symbolises his mother, there is likely to be some impairment of potency in his relationship to her on this account.

The feeling of greatness or expansion that comes through perfect relaxation in mother's arms is a compensation for the

later and similar feelings that come from genital potency. To the degree that he is deficient in the latter he will compensate by the former. Perhaps there is not so much difference as interchangeability between potency and mother need. While the former is genital the latter is largely oral. One's impression is that if this man were more sexually adequate he would not need to go in for drinking and gambling in order to feel greatness that way.

Thus we may again see that the pattern of a war neurosis is inextricably bound up with the pattern of early emotional development even down to the Oedipus complex. The human psyche must either be anxiety-free on account of a confidence in its own full genital potency, or its confidence, and its defence from anxiety, must lie in its close attachment to the Almighty Mother or the Almighty Father imago. I would go further and say that unless the mother is conceived of as an all-powerful phallus possessing imago, she will be inadequate for this purpose of protection; the father imago also will be a necessity. In the absence of these supports anxiety supervenes, compensatory mechanisms, symptoms, delinquencies are adopted, and breakdown inevitably follows.

The mechanism of the process though at present obscure may be as follows. It is only if the almighty phallus is favourably disposed to the infant phallus that anxiety or fear will be sufficiently assuaged to permit the latter to function freely and develop toward its own orgastic adequacy. Unless this is achieved accumulated somatic tension cannot be adequately discharged and remains dammed up within the organism, accumulating to an extent that damages its internal functioning.

The war neurosis is no exception to the general rule applicable to all nervous and mental disturbances. They differ only in their superficial traumatic or precipitating elements. They all have an identical nuclear pattern traceable to the original conflict between libidinal development and anxiety repression.

Hence "short treatment" must unfortunately always be synonymous with "incomplete treatment". The degree of incompleteness may vary between the stage of transference regression to anxiety-free babyhood or transference regression to the stage of the growing boy's rebellion against being forced to play the feminine rôle to his father's or mother's masculinity. In any case it has little or nothing to do with the mere revival of a war

amnesia. Anxiety was the cause of that amnesia and anxiety will remain after its removal. Thus the rationale of "cures" by narco-analysis is probably never that which its advocates suppose. The transference element has eluded them.

Nevertheless it may be argued that in war-time, with large numbers of sufferers to be dealt with, it is better to distribute our energies over the many than to confine them to a few, leaving the many totally uninvestigated. The position is very like that of a general practitioner with a crowded waiting-room. He may find cursory treatment of the many more practicable than exhaustive treatment of the few. As a result many are treated, but none is cured. Mental out-patient departments are similarly placed. The question arises as to how closely psychotherapy should approximate to these extemporaneous ideals or at what point between these and the ideal of complete analysis it should take its stand. A correlative question is as to how far it can afford to endanger its reputation by a succession of failures and relapses.

Epilogue: Six months later, with these questions in mind, I wrote to the ex-patient whose case is here recorded. As his attendances had amounted to only two or three dozen, I feared the worst. This is the reply I received:

"I have received your letter, by a coincidence at a time when I was feeling I ought to write and let you know about myself.

"I have no time to do so at present, but will try to write you fully either this week-end or the next. For the present I will content myself with saying that I am very busy and very happy with my work and loving every minute of my life here."

It is significant that his promise to give a fuller account of himself never materialised, in spite of two reminders.

The conclusion is that he is still the victim of unanalysed transference conflict together with the dangers inherent in such a condition.

CHAPTER XXXII

THE THEORETICAL STRUCTURE OF PSYCHO-ANALYSIS¹

The Essence of Clinical Theory: As this is essentially a clinical work, I have attempted to cover the field of technique fairly comprehensively (though admittedly only in outline), technique being the final instrument, or rather the complete armoury, of the practical application of clinical psychology. The same comprehensive treatment is not necessary in such work as this in our concluding description of psycho-analytical theory, the structure of which analysts are the first to recognise as being merely provisional, and subject to modification and expansion in the light of further discoveries, achieved through an application of the technique or otherwise.

In reference to the *application of psycho-analytical theory*, it should be pointed out that, from a clinical point of view, psycho-analysis emphasises three main aetiological factors in the causation of a psychoneurosis. (1) The first is the *current factor*, usually an actual frustration of present-day libidinal trends, a frustration which the individual has not succeeded in overcoming. This is the precipitating factor. It is normal or healthy for the libido to flow outwards towards current situations in the present-day environment. So long as it is gaining its satisfaction or absorption in this activity health is maintained; but, with an intolerable frustration the forward drive of libido is arrested and it is left with no other course than that of the second aetiological factor in the production of illness, namely *regression*. (2) Having been frustrated, the libido now *regresses* along the path previously pursued in the course of emotional and psychological development. This regression stirs up, successively, different stages along this previous path. Contact with environmental reality is progressively lost, and a state of what may be called *introversion* proceeds. (3) In its retrograde or regressive path the libido is naturally attracted to those *fixation points* at which it lingered unduly, or at which a certain residue of its energy

¹ The reader may find this chapter easier to understand after reading the chapter on "Topography and Mechanisms" which follows it.

remained, during the course of emotional development from birth onwards. These fixation points are usually associated with some erotogenic zone, such as the first or second oral, marking the earliest of the important pleasure-giving regions of the body, the anal zone as a successor of these, borrowing its emotional patterns largely from the patterns formed in the first stage of libidinal development, and finally the urethral, phallic and genital, the last marking the final stage of libidinal organisation with whole-object attachment instead of the predominance of auto-erotic interest and part-object attachments associated with the earlier erotogenic zones and fixation points.

According to the degree of regression of the libido and the degree of activation of various fixation points the neurosis will revive infantile conflicts and take the form appropriate to them, reactivating the patterns previously laid down, and thereby giving their particular character to the neurosis and its symptom-formations. Thus the neurotic is found to be absorbed with conflicts which have relatively little or no relationship to reality or to the *actual* conflicts with which the healthy or normal person is engaged. His energy has been, to the extent that he is ill, transformed from a healthful, forward drive and preoccupation with reality, to a backward or regressive movement and a preoccupation with an unreal and obsolete past and the unrecognised conflicts which were peculiar to it. Thus, for instance, in hysteria it is said to be the Oedipus complex which is activated by this libidinal regression, the Oedipus complex belonging to the genital stage of libidinal organisation with its whole-object (originally the parents) attachment. This accounts for the characteristic readiness and strength of transference phenomena in this particular neurosis. In obsessional cases the regression is to the anal-sadistic stage with its characteristic tendency to ambivalence and part-object attachment, though, of course, some elements of the later genital stage to which the libido had to some extent progressed, are as it were drawn back into this earlier stage, so that although the erotogenic zone is essentially anal rather than genital, its attachment to persons, even to some extent in the form of whole-objects, is often palpable. Thus the case of obsessional neurosis described in Chapter XVII responded anally (though also to a lesser extent genitally) to persons in his environment. For instance, if a woman to whom he was attracted was alone in his presence he experienced

sensations not only in his phallus but principally in his anus, usually in the form of a psychogenic desire to defaecate. But if any person was heard moving about the house while he was seated on the lavatory, all efforts to defaecate terminated abruptly. This was particularly the case if the person happened to be his father.

In psychosis the regression is said to be to still earlier stages. For instance, in manic-depressive psychosis to the later oral (cannibalistic) stage, and in schizophrenia even right back to the earlier sucking stage. The degree of introversion and auto-erotic preoccupation of the libido, with relatively complete withdrawal from reality, is therefore often extreme.

But all so-called normal persons are to some extent the victims of various degrees of libidinal regression, and differ from one another chiefly in this respect and in respect of the strength of their various fixation levels. Our preoccupations with oral (*e.g.* gustatory, chewing, smoking, kissing, speaking and other oral) interests, the strength, quantitatively and qualitatively, of our anal, direct and sublimated, interests, our genital, unsublimated (including fore-pleasure, perversions, etc.) and sublimated dispositions, all serve to characterise our primary libidinal development, and in their degree and relative strength to distinguish one person's disposition, temperament and character from another's.

In so far as, by the successive outward as well as inward searchings of libidinal interest, these psychic dispositions obtain objectivisation, particularly in mass form, in affecting our environment, we create a material and sociological world which is in every respect representative of our internal psychic dispositions.

Thus it is that psycho-analytical discovery and the insight it gives into the mind of man extends its field beyond the consulting-room and produces the key, not only to an understanding of the mind and its abnormalities, but to all the expressions of the mind—in short to the structure and meaning of the patterns of human culture, to sociology, civilisation and all that constitutes the world of man.

Historical: These theoretical concepts will be better understood if we first review in brief outline the development of the psycho-analytical theory from its inception by Freud.

Before this Breuer had shown in his famous case of hysteria

that the revival of forgotten memories, achieved in that instance through hypnosis, together with re-experiencing of the emotions originally attached to them—a process which he subsequently called “abreaction” or “catharsis”—had some therapeutic effects. Freud, who had previously studied with Janet under Charcot and had been much impressed by one of Charcot’s “off the record” remarks that a particular woman patient would never get better because her husband was impotent, seized upon this discovery of Breuer’s as the clue for which he had been seeking. In collaboration with Breuer he published their *Studies in Hysteria* (1895). Having found that the hypnotic method was unsatisfactory and that, after all, its main purpose was to remove resistances to memory, Freud first showed his unusual genius by concentrating attention on these resistances and discovering a method of dealing with them which, unlike hypnotism, was applicable to practically all patients, namely, the method of *free association of thought*. Through this master instrument resistances were revealed as they arose and access was facilitated to that vast and hitherto unsuspected region of the mind which Freud called the *unconscious*. It should be here stressed that psycho-analysis, unlike all previous psychologies, including even McDougall’s Hormic Psychology, is essentially the psychology of the unconscious mind—that region of the mind which is inaccessible except by the use of special instruments such as hypnosis and free association of thought.

For several years after, Freud worked in isolation, until, with his publication of *The Interpretation of Dreams* in 1900, he elaborated his concepts of “repressed wishes”, “condensation”, “distortion”, “displacement”, “symbolism”, “secondary elaboration” and other unconscious mental mechanisms, and the distinction between “manifest dream thought” and “latent content”, all of which will be later explained.

Development of the Libido: Freud’s attention continued to be devoted principally to the surprising revelations of the nature of the unconscious mind, the chief ingredient of which, as revealed by the process of free association of thought, appeared to be a dynamic force which he called *libido* and which he produced evidence to show (in his *Three Contributions to the Sexual Theory*, 1905) passed through a number of vicissitudes from birth to maturity. On account of its expression under analysis being so largely in the form of sexuality, he regarded it as

essentially the energy of the sexual instinct, but was able to trace its development long before the manifestation of anything which is ordinarily called sexual; indeed, he showed that practically from the moment of birth the infant exhibited this "libidinal" urge even in its physiological activities.

Erotogenic Zones. *Oral:* The most conspicuous manifestations of this urge or lust were regarded by Freud as primarily connected with the instinct of sucking, which stage has therefore been called the first oral stage of libidinal development. Next, with the eruption of the first teeth, this urge took on a biting quality designated as the second oral stage. *Anal:* At a slightly later date sensuous preoccupation with anal feelings and activities appeared to predominate as a process of libidinal preoccupation and satisfaction. At first these were chiefly of an expulsive nature (first anal-sadistic stage), subsequently taking on a quality of control and retention (second anal-sadistic stage). There is evidence that at all these stages the psychic life of the child is libidinally preoccupied with a world relating to the sensuous feelings from these regions of its body. Satisfactions are essentially auto-erotic, that is to say, achieved in relation to its own person, but in so far as it enters into relationships with the outside world, consisting at that stage of "part-objects", it has phantasies (unconscious in later life, but revealed during the process of psycho-analysis) of incorporation (through the mouth) and of expulsion, control and retention by the anus. Thus it lives in a psychotic and omnipotent world of its own. *Urethral:* Urethral "experiences" are in large part psychologically an extension of the predominantly oral and anal world.

These areas of the body—it will be noted anatomically characterised by the places where mucous membrane approaches or comes into relationship with the skin surface, that is to say where the internal physiological world forms relationships with the external environmental world—are designated "erogenic zones", and the instincts that achieve libidinal gratification or frustration at these zones are named by Freud "component instincts", "component" because analytical evidence shows that they enter into the formation in maturity of the full genital sexual instinct. This maturity is approached through a further zone becoming progressively more libidinised. *Phallic:* This is called the "phallic" (though in females it is actually the clitoris) erogenic zone.

Projection and Introjection: The psychological importance of this description of libidinal development is evidenced by the fact that the developing infant's relationship to his environment undergoes progressive alterations which are undoubtedly and essentially related to it. For instance, in these earlier phases he plays havoc with reality, projecting or tending to project all unpleasant or painful sensations whether emanating from the interior of his body or elsewhere into his environment, whilst at the same time he tends to introject all objects which produce satisfaction and to regard them as parts of himself. This helps him to maintain a good "interior" world at the expense of a bad or inimical "exterior". The psychosis called paranoia obviously has much of its source in this phenomenon.

Part-Objects, Whole-Objects and Ambivalence: Further, in regard to his relationships to the external world: while at the earliest stages of libidinal development he is essentially auto-erotic, he does have a relationship to what are in psycho-analysis called "part-objects" (for instance the mother's nipple) rather than "whole-object", such as the mother as a personality. This tendency to part-object attachment, in preference to whole-objects, remains to a variable degree throughout life, and is perhaps even normally revealed by such phenomena as erotic interest in breasts, hair, legs, genitals and so on.

With the advent of the predominantly phallic stage of development there is evidence that object-love proper becomes possible as an environmental relationship dependent upon this stage. According to Abraham, however, the characteristic of this stage of object-love is an *exclusion* of the genitals as objects of interest, suggesting of course that the object-love is not yet exactly whole-object love. Signs of a continuation of this stage, or a regression to it, are common in adult life.

Abraham also characterises all these stages, with the exception of the earliest oral or sucking stage, as "*ambivalent*", which means that they include an admixture of hate as well as love. The first oral stage on the other hand he regards as pre-ambivalent. It is only with the advent of what is called the final "*genital stage of libidinal development*" that this ambivalency largely disappears and that the outward expression of the libido in the form of object-love becomes whole-object love and achieves a possibility of gratification from a love relationship to a person as a whole-object. It will be appreciated how closely the social

order, to mention but one thing amongst many, is dependent upon the achievement by individuals of this final stage of libidinal development.

Resistance to the Theory: To those without adequate analytical experience much of this theory of libidinal development will seem positively repellent and perhaps therefore incredible and altogether unsatisfactory. Its justification is that it is based entirely upon material produced during the deep analysis of patients by means of free association of thought, and on the analysis of transference. Indeed, the difficulty of accepting it without discovering, through a process of personal analysis, its existence within one's own unconscious, and without the repetitive concurrence of clinical material, is itself evidence of the fact that it has been subjected to a great deal of repression and that the repressive forces are still operative. Freud himself, perhaps with characteristic *naïveté*, when he first attempted the expounding of even a modicum of this sexual theory of the neuroses to an analytically inexperienced audience, was greeted with a stony and incredulous silence seldom meted out to a professor by his class. This unique and perhaps disgusted rejection of a scientific exposition by young men who were either secretly preoccupied with their own sexual struggles or perhaps boastfully enjoying mutual recitations of their freedom from its bondage, is thus, like the general rejection of the sexual theory by persons who owe not only their social order but their very existence to its operations, itself overwhelming evidence of both its substantial truth and of the resistances and repressions which have caused it to recede into the unconscious.

Evidence during the deep analysis of psychoneurotics and others, including normals, is overwhelming, though hidden from public scrutiny. However, the existence of the enormous variety of sexual perversions can obviously be explained on no other basis. An element contributing to the unpopularity of the theory is Freud's "libellous" assessment of the heavenly infant as being by nature the possessor of all possible perversions and castigation of him as a "polymorphous pervert".

Narcissism: At a later date the theory of the libido was developed still further. In the course of tracing libidinal progress from auto-eroticism to the fully developed stage of object-love, Freud, in 1914, interposed a theoretical stage at which the loved object becomes primarily the lover's own person. This he

designated by the term "narcissism" after the story of Narcissus who fell in love with his own reflection. The libidinal situation is here in part object-love and in part auto-erotic in so far as the loved object is oneself, together with one's own auto-erotic satisfactions. It thus provides the transition stage to object-love proper. Nevertheless all persons have some element of this narcissism, which may be regarded as a fixation, remaining with them. Females are said to have more than males in so far as they are socially permitted to study their reflections, make-up, etc., but this suggestion may be balanced against the generally assumed greater egotism and egocentricity of the male. Possibly the sexes have an equal amount of narcissistic fixation of the libido, though it may reveal itself in different forms. The theory of narcissism obtained support not only from a study of character, but also from a study of psychopathic abnormalities, including, particularly, some of the psychoses.

Latency Period: Still under the heading of "development of the libido" we may consider its outward direction also, to objects in relation to which there is no sexual end in view. This is a process which is said to take place particularly, or initially, at the intermediate stage between infancy and childhood, and is said to be due largely to a frustration and repression of the libidinal genital aims at the Oedipus stage of object relationship. It is then that the so-called latency period becomes more pronounced and the infant has almost perforce, owing to the intolerability of the Oedipus complex, to direct his interests to symbolical objects which have no prospect of fully gratifying, on a sexual pattern, the aim of his instincts. Such objects proceed from toys and similar playthings to the gadgets and circumstances which comprise human culture. It should be mentioned here that a great deal of this libidinal diversion takes place from pre-genital foundations, namely from the levels of the less-organised component instincts. Each of these is said to have special contributions to the formation of the various sublimations, substitutions and displacements, and the part-satisfactions derived from them.

Aggressive Instincts: At a much later date in his investigation of the unconscious mind, and specifically with his publication of *Beyond the Pleasure Principle* (1920), Freud came to the conclusion that compulsive tendencies or urges emanating from the id were not exclusively libidinal. He detected another and perhaps

antithetical principle at work. This manifested itself clinically in a *compulsion to repeat*, a compulsion which was far from being motivated by libidinal or pleasure-seeking urges. By pursuing his investigations he discovered that this new-found id-instinct was responsible for aggressive and destructive trends, and though capable of libidinisation, that is of uniting with the sexual instinct, was essentially distinct from it. By a process of deduction Freud came to the conclusion that these non-pleasure-motivated tendencies or compulsions emanated from a source which he called the death-instinct since its trend was to undo evolutionary development and to get back, through however circuitous a route, essentially by a process of retracing the past, to the original inanimate state. Though this theory of Freud's has not been accepted *in toto* by all psycho-analysts, certain clinical phenomena, particularly aggressive manifestations, such as those demonstrated in the case of epilepsy in Chapter XVI and some of the compulsive manifestations in cases of obsessional neurosis, show evidences in support of it. However, this concept of the death-instinct, even in its more clinical forms of aggression and compulsion, has not proved so fruitful psycho-analytically as the theory of the libido and has not been developed to anything like the same extent.

The Repressing Forces: Freud's early interest had naturally been devoted almost exclusively to the new revelations from the hitherto relatively inaccessible unconscious mind, consisting essentially of instincts and their components and of psychic material which was repressed from consciousness. But in 1923, with his publication of *The Ego and the Id*, Freud showed that his attention had for some time been turned from his preliminary preoccupation with the repressed to a new focus of interest in the nature of the repressing forces responsible for this repression. Evidences of their existence reveal themselves at every turn during the conducting of an analysis, and indeed it is these forces which have to be dealt with to some extent before we can discover what they are resisting. They appear to have as it were their topographical locus not so much within the conscious or accessible ego, but principally at a somewhat deeper and unconscious mental level. Psycho-analytical investigation, both in Freud's hands and since, has shown that the earliest and unconscious organisations of these repressing forces begin at an early age and are brought about by very primitive mental mechanisms.

Super-Ego: This very early and largely unconscious portion of the ego has been called the super-ego. It can be regarded as a sort of unconscious and irrational conscience, and, though its origin was at first thought to be connected with the Oedipus complex, it has since been found that it has important roots at a very much earlier age. Ferenczi spoke of a "physiological fore-runner" of it in connection with bowel education and the acquiring of what he called "a severe sphincter morality". But even earlier elements have since been demonstrated, particularly by child analysts. Its formation has, as we might have expected, been shown to be a slow process, due essentially to primitive mechanisms connected with as early a stage of libidinal development as the oral. At this stage and subsequently when the child's pleasure-seeking instincts are frustrated, and aggression thereby aroused (which in turn becomes frustrated and repressed), repressed affects, being uncomfortable, are projected on to persons and things in his environment. This process is rendered easier by his inadequate distinction between the self and the non-self. In consequence of this projection all the most aggressive and destructive tendencies in himself he attributes to figures or imagos around him, thus endowing them with his aggressive, destructive and sadistic characteristics. In fact, at the oral stage (and subsequently) he fears that they will gobble him up, in the same way as his aggression at one time phantasied himself gobbling them up. He thus believes the world (as did some of the ancient savages) to be filled with such terrifying objects that finally he can only escape anxiety (and that only in part) by the process of introjecting and thereby, as it were, controlling these same fearsome imagos. This introduction is, of course, a mental process, and creates within his own psyche a super-ego infinitely more primitive, harsh and severe than any real persons, such as parents, could possibly be—a super-ego of which he is then and thereafter inordinately terrified should he infringe the least of its behests.

It will be seen that the super-ego is thus originally formed from the infant's own frustrated and inhibited instincts. As at this stage of development these are largely connected with oral—and anal—sadistic phantasies, this nuclear super-ego is similarly most primitive and terrifying. Fortunately, at the same time many "good" external objects are also introjected and go to build up that portion of the super-ego which has been called

"the ego ideal". This serves almost as a libidinal object for the achievement of desired qualities, thus compensating to some extent for the deprivation of instinct gratifications of a more primitive type. This direction of the libido may be regarded as narcissistic.

Compliance with the super-ego's behests is the essential condition for producing full self-satisfaction; and defiance of its demands, including sometimes even the impossible moral standards set up by it, is responsible for every degree of dissatisfaction with oneself, from the minor phenomenon of self-reproach to severe depressions, melancholia, self-punishment—in a variety of ways not excluding physical illness and even self-destruction. However, there are various other ways of gratifying an outraged super-ego, the commonest of which is that of projecting one's own "criminal" id tendencies on to another person and using him as a scapegoat for unlimited super-ego vengeance and satisfaction.

All these processes are in greater or lesser part at work within every psyche, abnormal or normal, and are responsible for the greater part of our social structure and its institutions. Thus we may see that the super-ego, formed as it is in large part from the most primitive aggressive and sadistic instincts, can be, particularly in the form of moral indignation, as injurious to the happiness of self and others, and to the welfare of the body and of the community, as any unbridled original id impulses. Indeed, under the influence of psycho-analysis it is commonly modifications of the super-ego which first take place, thereby lessening the severity of the patient's repressions, freeing more unconscious material for analytical investigation and liberating certain quantities of repressed libido, which last thereupon attach themselves to the person of the analyst and so build up the transference situation. This transference situation is nothing more or less than the newly freed libido of the repressed Oedipus complex finding new life within the *analytical session*.

The Ego: The remaining portion of the psyche, namely that portion of the ego which is not included under the subdivision called super-ego, has to do essentially with reality and our relationships to it. Psycho-analysis teaches us that it is never a wholly free and independent agent. Its reality appreciation and its activities in regard to environment are always influenced, and more or less vitiated, by instinct-pressure on the one hand

and super-ego insistences on the other. Nevertheless in health it remains sufficiently effective in its functions to ensure survival—although here we must remember that limited relationships to reality at a more primitive level than that of ego development were always present and, in the form of reflexes, conditioned reflexes and instincts, have evidently ensured our survival phylogenetically and ontogenetically, from unicellular animalcule and oosperm, through all the multicellular stages of evolution and development, in spite of the ravages of carnivora, disease and wars.

Thus the modern findings of psycho-analysis would seem to support the conclusion of Erasmus (as early as 1509): "See then here what Jupiter has done. . . . He has endowed man with reason in singularly small proportion to his passions—only, so to speak, as a half-ounce to a pound. And whereas he has dispersed his passions over every portion of his body, he has confined his reason to a narrow little crevice in his skull."¹

¹ Erasmus, *The Praise of Folly* (published 1509).

CHAPTER XXXIII

THE MIND: TOPOGRAPHY AND MECHANISMS

PSYCHO-ANALYTICAL theory may be clarified by a short description of the topography of the mind and its mechanisms.

Topography of the Mind (cf. diagram, p. 437): Purely for descriptive purposes we shall begin with a concept of the simplest possible mind which we may represent diametrically by a circle. In Freudian terminology we would call this the "id" (or "it"). Such a mind does not really exist and the concept is purely an abstraction, for even the most primitive animal may be regarded as having some proportion of ego. But we may be permitted to take a developmental point of view and regard such a mind as existing in an embryo. This mind we shall conceive of as being a world to itself. It has no organs of perception and no contact with environment or the world outside itself (compare here the auto-eroticity of the earliest years of life). It is simply a reservoir of innate or inherited urges, instincts, desires or wishes. It might be regarded simply as body without brain or mind.

Clinical psychology, or at least its analytical branch, is forced to regard this id as the source of all the dynamic energy of every level of the mental apparatus, and, therefore, of primary importance for its purposes. Its physical basis might be regarded as a sort of spinal cord which was rather more than a mere reflex apparatus in that it embodied those phylogenetically elaborated "reflexes" called instincts. The id receives stimulation from all somatic sources and accumulates energy or tension which, like the spinal cord, it would automatically discharge along inherited paths.

Now, last of all (especially after birth) it is receiving stimuli from the external world of reality. Such stimuli, firstly received from the sense-perception organs which are in contact with reality, produce some, shall we say, localised modification of a portion of the id. Lamarckian and Spencerian evolution would contend that it is by dint of these stimuli that the sense organs themselves are evolved, and thus better convey the stimuli from

the external world to this undifferentiated mind.

The new structure thus becoming created by these stimuli may be called the primitive ego. In our diagram we may regard it as a sort of bubble created by these stimuli on the surface of the circle. It is that part of the mind which gradually achieves some cognisance of environmental reality, or more strictly speaking—for here we must remember that Kant has pointed out that we have no reason to assume that our minds can ever become cognisant of the "*thing in itself*"—registers our reactions to the impingement of reality stimuli and causes us to react to them.

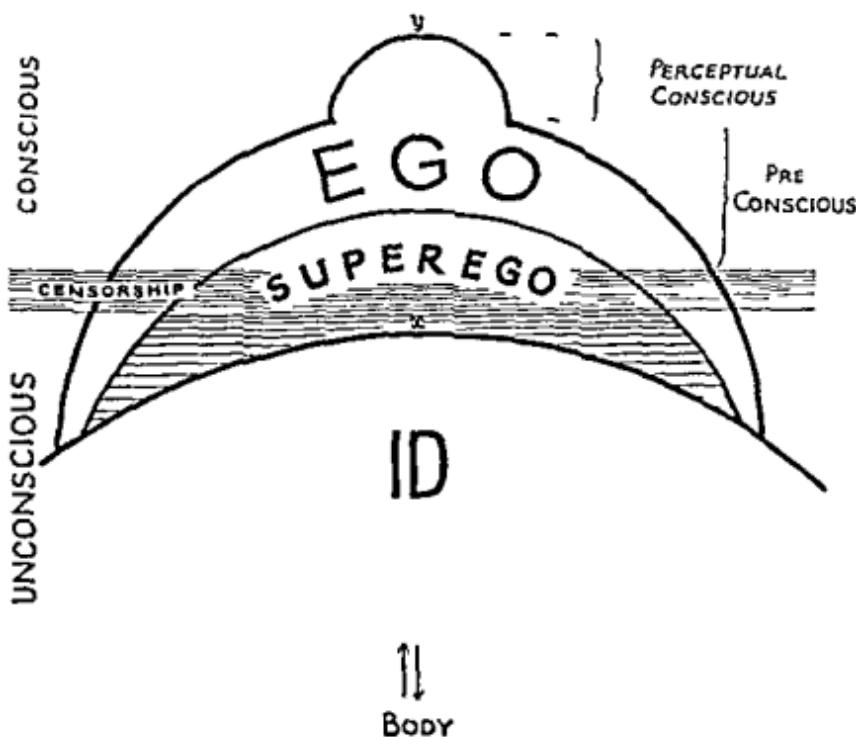
Early in individual life a highly organised group of stimuli begin to take effect on the primitive mind of the developing infant. I refer to the effect of people, particularly of parents, their ideas and ideals. The specific effect of this new human environment is largely in the form of a prohibition or frustration of the formerly free expression of instinct urges.

It appears from psycho-analytical evidence that the tensions resulting from frustrated instincts arouse the reaction of aggression which, of course, in turn becomes frustrated from natural expression. It is then that the primitive mental mechanism of *projection* on to the frustrating objects and persons takes place, as has been previously described. Projection means that the mind, being prevented from expressing its own tendency, *feels as though* this tendency is being directed against it from the environment and attributes it to the things and persons around. But this process, as has been pointed out, is merely a preliminary to the subsequent *introjection* of the erroneous concept of the frustrating objects and a consequent building-up within the mind of an organisation which is felt to operate in this frustrating manner, and at the same time to threaten the developing ego with the same primitive aggression should it infringe the prohibitions and commands of this introjected frustrator. In this way the *super-ego* is built up and may be regarded as comprising the main portion of the newly developing infantile ego.

In so far as the process begins at an *oral* stage of libidinal development it may be said that the infant's cannibalistic urges are projected on to parent images and subsequently (cannibalistically) introjected. This would explain how it is that they assume such terrifying and all-devouring characteristics. This super-ego, comprising as it does the greater part of the infant's ego (or reality principle), as yet very insignificant, is the

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the external world to this undifferentiated mind.

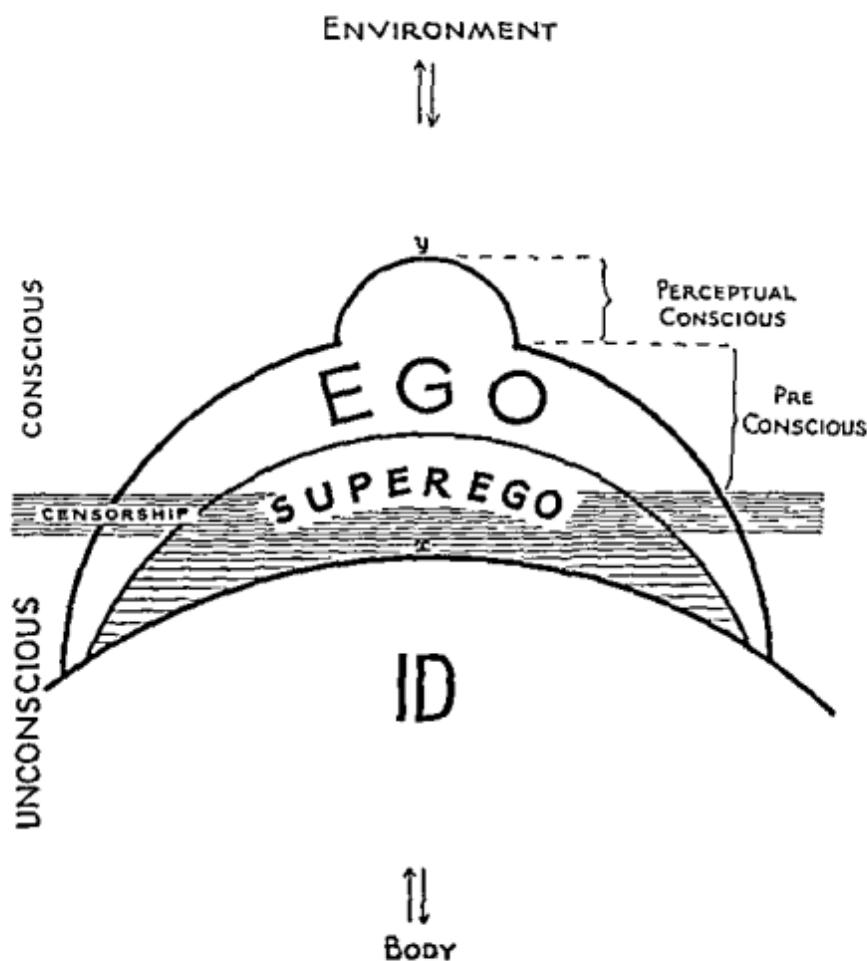
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principal, if not the only force opposed to immediate instinct (or id) gratification.

The mind is now not so simple. There are two opposing forces at work within it. The function of each is very different. The id merely wishes to relieve itself of tension without any consideration of reality, whereas the super-ego has the function of forcing the ego, largely through fear if it does not obey, to enter into opposition to the insistent demands of instincts emanating from the id. Thus we come to the important psychological concept of *conflict*, though this is only one form of conflict (conflict can also be between one instinct and another).

This primitive ego, or super-ego, deals with these instinct urges by means of a primitive mental mechanism which has little to do with such conscious processes as logic or reason, in fact, its tendency is to react to them on the all-or-nothing principle—it is not sufficiently developed to enter into parleys or to form compromises—either by full acceptance or by total rejection. The method of rejection is the simple one of *repression*, which consists in keeping them out of consciousness, or turning them out if they have entered, just as though what one were not conscious of did not exist.

Perhaps an explanation for the phenomenon of repression is that the primitive mind is not capable of enduring in consciousness unexpressed desires or undischarged urges. Consciousness of them provokes immediate and inevitable action. Therefore there is little distinction between its world of thought and its reality sense. The two are confused and identified. Therefore to keep an urge or idea from action or reality expression it must keep it out of consciousness. It must *repress* it because it cannot suppress it.

Naturally this process creates an illusion—and that often only a temporary one—of non-existence. The repressed instinct urges continue to flourish within the mind, albeit disregarded or unknown to its conscious levels. In this way there comes into being a special region of the unconscious mind, a region the entry of which into consciousness is resisted, and which it is the special function of psycho-analytical technique to relieve from repression; for it appears that repressed material is neither non-existent nor at rest.

The process of repression has to be conceived of as a dynamic process constantly at work and constantly absorbing mental

energy to maintain its function. At the same time the urges that it is repressing continue to be unceasing in their demands so long as life lasts. Apart from this wasteful absorption of mental energy, certain elements of the repressed material frequently break through the repressing forces and emerge in the form of symptoms, or of other instinct-driven conduct, whether repudiated by the repressing ego or not.

We may pause for a moment to consider where the ego gets its everlasting energy from. The answer is interesting. The ego is a modified portion of the id, and it gets its energy actually from the id sources which it is occupied in opposing. This process is called anti-cathexis. Cathexis is the libidinal investment of an idea or tendency, and anti-cathexis is said to occur when this libidinal investment is as it were taken over by the ego to oppose the idea or tendency which was formerly invested with it. In consequence we get an equally powerful and insistent impulse in the *opposite* direction to the original tendency. This process may become conspicuous in such an illness as obsessional neurosis where the *excessive* reinforcement of the opposition—opposition to what the instinct wished to do—is characteristic of the disease. For instance, an obsessional patient with strong destructive and dirtying instincts, such as the case described in Chapter XVII, may be constantly preoccupied with *precautions* against dirtying or destroying, and with obsessional cleanliness (cf. the hand-washing ritual of many obsessinals). The mental tendency which is thus formed by anti-cathexis has the same *compulsive* insistence (its essential characteristic) as the repressed instinct from which it derives its energy. A less striking manifestation of the same mechanism is apparent to the psychologist in the violent repudiation of violence, for instance, the conduct of crowds who lynch (*i.e.* murder) a murderer, and of the State which, with ego-placating rationalisations, behaves similarly.

To return to our concept of conflict between id and ego, and the process of repression whereby the ego endeavours to keep the id in order. The task of the ego is a difficult one. It constantly fears the vengeance of the super-ego if it is overwhelmed by the more powerful id. At the same time it has, perhaps fortunately, so slight an appreciation of reality as we know it that it is constantly being carried along by the id without recognising that opposition is called for by reality. So that the early ego, in

spite of its ruthlessness in places, may still be as mad as the id in other respects.

This brings me to another concept which is of special interest. Whereas all *psychoneurosis* is regarded as being the result of conflict between the id and ego (strictly speaking between the id and the super-ego) in which the ego maintains its contact with reality relatively unimpaired, *psychosis* (mental illness, insanity), on the other hand, is regarded as a state in which the demands of the id have unduly influenced the ego—the ego has as it were turned too sympathetic or complaisant an ear to the id—with the result that the ego's relationship to reality has been impaired, so that now conflict would lie between the ego and its environment. I think this is an interesting conception and worth retaining in spite of the fact that modern psychiatry has some justification for coming to the conclusion that "The distinction between neuroses and psychoses is at times convenient but without substance",¹ and as we showed in Chapter XXI, pp. 265-6, Freud has pointed out that there is *some*, as it were, *localised* degree of ego-impairment even in a psychoneurosis.

Impairment of the ego's relationship to reality is also commonly brought about through an undue influence from super-ego sources, in fact this is so common, and usually shared by so large a majority of people, that the result, instead of being called a mass psychosis, is commonly regarded as a cultural, national or religious ideal. The difference in results between it and a psychosis is that while the latter destroys the individual, the former is commonly responsible for mass destruction.

In our diagram the conflict in nervous disturbances would seem to lie principally at "X" between the id and the ego, whereas in psychosis the ego has already been overwhelmed by id forces and the conflict would lie principally at "Y" between the ego and environmental reality. Similarly in the third suggested instance where the ego's reality sense has been impaired by super-ego influences.

The primitive mind is relieved to some extent of conflict at the first level, but obviously has a considerable amount of this conflict at the second level. We all recognise, for instance, that a child's relationship to reality is imperfect, and that he may not be unduly conscientious about it however over-conscientious he may be about some things which do not matter so much on

¹ Mapother and Lewis in Price's *Text Book of Medicine*, 6th Ed. p. 1821.

a reality plane. So-called adults are to a varying degree in a similar position. But in general, reality, as the child sees it, is often very different from reality as an adult sees it; and this is perhaps fortunate for him, otherwise the burden of conflict between the ego and the id would most certainly lead to a neurosis. Briefly, one may say that the child is psychotic rather than neurotic, and, as I have indicated, I would extend this generalisation to us all, however adult we may pretend to be. Wars in the outer world may save us from intra-psychic wars. Human insanity may be collective, dramatised and manifest. Civilisation with all its evidences of neurosis is certainly not free from psychosis also.

Topographical concepts include, besides the id, super-ego and ego already mentioned, the equally important concepts of *conscious* and *unconscious*. These are conceived as cutting across the other topographical divisions of the mind in such a way that while the id and the greater part of the super-ego are wholly unconscious, most of the ego proper, but not the whole of it, is conscious.

It has been pointed out that consciousness, in the form of attention, can at any one moment only be focused on an extremely small field, whether that field consists of observation of external reality, or whether it consists of intra-psychic material such as memories. This portion of the ego, actually alive and functioning at the moment, is called the *perceptual conscious* (see diagram), whereas memories and similarly stored-up material, not actually conscious, but available with a varying degree of direction of attention towards them, are regarded as lying in a portion of the mind designated as the *pre-conscious*. Pre-conscious material is not subject to repression as is unconscious material.

As life goes on and as new experiences accumulate, the very early ego has, as it were, successive layers of further modifications superimposed upon it. The later, or adult ego is developing. There is clinical evidence that a portion of early ego, especially the super-ego, remains unaffected by these successive experiences and retains its primitive form. It is now largely unconscious, but it still shows evidence that it is very much alive in exercising its early function of opposition, often an opposition which has no reality justification, to id demands. We are all the victims of some modification of our reason, or adult ego, by a primitive conscience, or super-ego, recognised, for

instance, as a bias (a "localised" psychosis) whether we are conscious of its existence or not.

It is a matter of some speculation as to why the greater part of the super-ego is unconscious, as it is topographically and functionally regarded as a *repressing* force itself responsible for keeping a large portion of the mind repressed and therefore unconscious. How comes it that the force which does or maintains the repression is itself unconscious? The answer is still in the realms of speculation, but as this is developmentally one of the earliest regions of the mind, and as it is from the first so intimately related to terrifying phantasy and intolerable conflict, it seems to me understandable that it should be repressed through its close *association* with these phantasies and conflicts.

We may now visualise the adult ego as standing as mediator between the conflicting demands of the id and the super-ego on the one hand and the requirements of reality on the other. There are constantly present intra-psychic tensions and conflicts between id and super-ego in addition to intra-psychic conflicts due to the opposition of one instinct to another within the id. Whilst the ego's function is to act as mediator between these conflicting demands, it must at the same time take reality into account, in spite of the fact that it itself is continuously having its reality appreciation impaired by the influence of the forces which it is endeavouring to deal with. When the ego fails to carry out its functions the result is a psychogenic illness. If a normal degree of reality adjustment is achieved only at the expense of emotional evidences of internal disturbances, the result is commonly called a nervous illness. If, on the other hand, the internal disturbance is "dealt with" at the expense of reality relationship, the result is called a mental breakdown, or psychosis. This is supposed to be so incomprehensible to the average person apparently because he is unaware of the fact that no ego, including his own, escapes impairment. In other words, none of us is perfect in his mental functioning. Analysis of the most so-called normal person very speedily reveals this to him. Ego impairment, at least before analysis, is not likely to trouble him so much as it may trouble others. What will trouble him more will be the intrusion of conflict, forcing its way through protective repression, into his conscious mind. The opposing forces in such conflicts, whether they impair the ego or not, if they carry the ego with them, break out in the form

of some ego-accepted behaviour. If they do not gain ego acceptance they are, nevertheless, constantly breaking out in some form of symptomatic behaviour.

We will find in every symptom, as in every form of human behaviour, belief or judgment, a contribution from each one of the various topographical regions into which we have here divided the mind. There will be first of all, as the source of the symptom, belief or judgment, the dynamic force of some primitive instinct, or a component part of such an instinct. There will be some element from the opposing super-ego. There will be some element, such for instance as epiposic secondary gain, into which the ego will enter, and, of course, reality will contribute some little part.

Theoretical Concepts: In contrast to the simplicity of this mental topography, the theory of psychodynamics and mental functioning makes use of such a vast number of theoretical concepts that I think it necessary for the sake of clarity to review these, even though some of them have been previously mentioned in the course of our topographical description. Thus: the instinct forces of the id are divided into Eros and Thanatos, or the life and death instincts, which manifest themselves respectively in the sexual instinct on the one hand and the aggressive (or destructive or repetitive) instinct on the other. In this contrast we detect the important concept of *Conflict* at its lowest and most fundamental level, but it should be borne in mind that these opposites can in some degree unite with each other—as we may see for instance in the phenomenon of sadism.

Again, there can be a functional conflict between the pleasure principle (which, generally speaking, means the discharge of energy or tension along the path of least resistance) and the so-called reality principle. The former is the special province of the id, and the latter of the ego.

It has been said that the id is the reservoir of mental energy. This can be conceived of as the steam-pressure within a boiler—the pressure that, passing through various mechanisms, sets the wheels in motion. Now this energy is clinically manifested in two forms corresponding to the two fundamental instincts. The form which manifests itself as repetition seems to be outside the pleasure principle and the reality principle, and is still relatively obscure, but the form which is principally responsible for making the wheels go round, the form which corresponds to

the steam-pressure in our engine analogy, that puts the whole mechanism into life and activity, is of the utmost importance for an understanding of mental dynamics. For conceptual purposes this energy has been, as it were, extracted from its instinct source, and given a name of its own: *Libido*. As previously stated, it can be conceived of not only as the energy or dynamic force of the sexual instinct, but also as capable of as many transformations, changes of direction and vicissitudes as the steam-pressure within the various tubes of the steam-engine. There is a vital quality about it which justifies this special conceptual abstraction. Though it includes the term "erotic", it is wider than this, for it includes even the energy behind the infant's urge to suck, and, indeed, the lust for life itself. Also it is regarded as lying behind any emotional attachment not only to all persons, but even to concrete objects and abstract ideas.

There is a libidinal feeling-tone in every portion of the living body, and it is conceivable that every living cell and organ contributes to it, even though there is no localisation to the source of these contributions. Localisation does, however, occur most markedly at specific places or regions, and these have in consequence been called the "erotogenic zones". We have considered them in some detail in the previous chapter. It should be mentioned that their erotogenicity may extend for a considerable distance around them, and, indeed, to some extent it includes the entire surface of the body and even its musculature and its interior. It was noted that these erotogenic zones are mostly at the orifices of the body where external things can be taken in to affect the vital interior and vice versa. It is probable that this is the physical basis upon which the psychological phenomena of introduction and projection are founded.

From a consideration of libidinal development through this succession of erotogenic zones, it will be seen that adult genital sexuality does not spring into being miraculously from nowhere, but that it is as it were a final stage of libidinal organisation having roots and origins in the erotogenicity of all living tissue and passing through many intermediate localisations before it is finally canalised in its fully adult form. There is psycho-analytical evidence that the foundation of this pattern is laid down in infancy, however latent or repressed it may subsequently become. Indeed, the infant's life is even more proportionately sensuous or sensual than that of the adult.

With the achievement of the genital organisation of this early pattern and consequent capacity for whole-object love, the sexual object, at least in unconscious phantasy, naturally tends to become the parent-image of the opposite sex. Put crudely it may be said that little boys marry their mothers and little girls marry their fathers. The reverse takes place in cases of inversion. This situation, natural or inverted, leads to extraordinary, though hidden, psychological difficulties as it entails conflict between emotions of love, hate and fear. The old classical play by Sophocles (*Oedipus Rex*), itself a product of the unconscious, dramatises the conflict that ensues. Each little Oedipus, like his classical counterpart, "extinguishes" his sexuality (cf. Oedipus put out his eyes) and goes, "blind", into the wilderness away from the desired object of it. In short, it is said to be a breaking-up of the psychological Oedipus situation which initiates the latency (school) period of libidinal sublimation and cultural achievement. The Oedipus struggle becomes repressed and forgotten, but in adult life the psychological tendencies and even the character fall largely into these early emotional patterns.

Fixations of libido to some of the early erotic regions precede the development of the Oedipus conflict, and so prevent a variable amount of libidinal energy from achieving full genital organisation. Regression to these fixation points occurs if normal development is frustrated; and it is transformations of the component instincts so fixated, rather than of genital sexuality, that are responsible for the majority of neurotic symptoms. For instance, in conversion hysteria there occurs erotisation by regression to that part of the body which presents the symptom. Clinical or analytical evidence reveals that the hysterical patient whose stomach is so sensitive or ticklish, is more or less anaesthetic or frigid in the genital region. Sexual perversions are the positive expressions of libidinal fixations as hysterical symptoms are their negative, resisted and transformed expressions.

The super-ego or ego may resist libidinal impulses and ideas emanating from the id. It may impose a censorship upon them and cause their repression into the unconscious.

If these forces are too strong for it and the ego is not confident of its ability to keep these unwelcome "enemies" repressed, it reacts with anxiety at the threat of their emergence. Subsequently, or simultaneously, the energy or libido of the repressed instinct reinforces the affect of anxiety and obtains its

expression through it instead of through the original instinct (cf. Chapter VII, "The Problem of Anxiety"). The result is what is called an "Anxiety State". This is what commonly happens in cases where the sexual instinct is being unduly stimulated without achieving relief of its consequent tension; for instance, in engaged couples who go in for much courtship and incomplete sexual satisfaction (cf. Chapter VIII, "Nervous Breakdown"). In any case, it is usual for these impulses and ideas to find a way of evading the censorship, as the id is forever trying to relieve its tension. They emerge by assuming all sorts of disguises and subterfuges to evade the censorship.

Primitive mechanisms which are made use of in the attempts of the unconscious to evade the repressing forces and gratify its wishes include various forms of *distortion*, *symbolism* and *condensation*. Distortion results from the work of the censorship whereby disguise or blurring of a disturbing object or idea takes place. Sometimes the accent is put on the relatively unimportant part of a dream or concept. Symbolism is similarly a mechanism for carrying the affect through the censorship by means of attaching it to a relatively harmless object and thus enabling it to assume an effective disguise. This is a characteristic part of "dream work" whereby the manifest dream is formed from the latent content, but the process is more generally employed in the substitution of objects and aims of cultural value for primitive objects and aims which were originally of a sexual nature.

Some of these subterfuges of the primitive levels of the mind may seem almost comical to our way of thinking, but are nevertheless very evident during analysis. For instance, in the interpretation of dreams where the *manifest dream thought* may make use of such symbols as knives, swords, spears, sticks or umbrellas, the *latent content* can often be easily seen to be concerning itself with heavily censored phallic symbolism where the affect attaching to a particular repressed idea is endeavouring to force its way through the censorship. An affectively charged idea, if its dynamic energy is by itself insufficient to drive its way through the repressing censorship, may join forces as it were with other ideas of similar affective tone and through their fusion a new *composite* formation is formed which, by dint of the combined energy of its component parts and by virtue of its disguise, forces its way through the censorship. The resulting image is then said to be produced by the process of *condensation*.

Secondary elaboration occurs when the ego takes a hand in modifying the new material, such as dream material, in such a way as to bring it more in line with conscious thought or reasoning. The dynamic energy, affect or emotion of id tendencies is commonly *displaced* on to ideas or conduct less heavily censored by the super-ego or ego. *Sublimation* is said to occur when these newly energised ideas or conduct are, far from being censored, really in keeping with super-ego and ego ideals, or when they are regarded as serving the reality advantages of the individual and of society. When, however, the repressed forces escape, *in spite of ego resistance* they may exhibit some manifestation which is contrary to the ego's wishes and injurious to its sense of security and well-being. There is then a state of conflict, and the escaped energy manifests itself in the form of symptoms, and the individual is suffering from a *psychoneurosis*.

Sublimation, substitution and symptom-formation and all human behaviour other than instinct behaviour are thus the result of the mechanism of *Displacement of Affect*. This mechanism, one of the many in the unconscious mind, is most important for our understanding not only of the mode of production of psychoneurotic symptoms, such as phobias, but also of all our sublimations and of the substitution of cultural values for the primitive instinctual and erotogenic valuations. Abundant illustrations of it have been given in the text of the cases described, and its mode of operation has been explained in their various psychopathologies.

Suffice it to say that, on account of the resistance or opposition to certain ideas (particularly primitive sexual ideas) and the ensuing conflict, these ideas, unwelcome to consciousness, become repressed into the unconscious, while the affect or emotion originally attached to them, being more dynamic, becomes dissociated and *displaced* on to other ideas which can be tolerated (or even welcomed) in consciousness. Thus the dynamic affect reaches consciousness after all, and gains relief and expression by means of this displacement.

In conclusion we may review the dynamics and mechanisms of the mind as follows:

Tension arises from somatic sources and accumulates in a sort of instinct reservoir called the id. Thence it would tend to discharge itself along the established instinct paths and emerge in the form of instinctive behaviour.

In the course of development the smooth and ready working of this process is held in check, first by external agents such as parents and reality, and secondly by the super-ego developed not so much by the influence of these external agents as by the very primitive mental mechanisms of projection and introjection—projection of frustrated and repressed aggression on to external agents and subsequent introjection of them as the embodiment of these repressed affects.

But growing tension is intolerable and the dynamic energy or affect of these instincts is for ever striving for relief of tension. This is achieved largely through the mechanism of displacement of affect whereby the affect attaches itself to ideas or forms of behaviour which are permitted by the censorship of super-ego and ego (sublimation).

If it fails to obtain relief in this way, a state of conflict will arise. This may resolve itself in one of several ways. Either the impulses and affects will be repressed, in which case there is a constant expenditure of energy on the part of the repressing forces often resulting in mental ineptitude, with alternating anxiety and exhaustion; or, in so far as the accumulation of tension becomes intolerable, it may regress and reactivate component instincts; or, with or without these intermediate processes, it will undergo some degree of displacement of affect, and break out in spite of the ego, displaying itself together with some portion of the opposition in the form of a symptom: or, last of all, it will cause modifications of the ego itself, disturbing the latter's appreciation of reality to a greater or lesser extent and thereby giving rise to a psychosis.

It only remains to be added that each and all of these processes are continuously taking place in every mental apparatus, the only difference between one mind and another being the relative energy of the forces at work, and the relative degree to which the various mechanisms are employed.

In other words, all persons display instinct behaviour, cultural or sublimated behaviour, symptomatic behaviour and psychotic behaviour. There is no ego whose relationship to reality is not to some extent vitiated by the claims which undischarged instinct tension and super-ego anti-cathexes make upon it.

Whether or not a psychotherapist believes in the psychoanalytical theory, and whether or not he uses the psychoanalytical method, it would be as well if he had a thorough knowledge of the former and a thorough training in the latter.

It is as well that a surgeon should have a thorough knowledge of anatomy and should be able to perform major operations

even if he is usually engaged in minor surgery. True knowledge and appreciation of psycho-analytical theory and method can be acquired only by submitting oneself to a complete psycho-analysis. Unfortunately, such knowledge and training are the exception rather than the rule.

The psycho-analytical method is based on the theory, itself the fruit of much analytical experience, that the roots of every neurosis together with the roots of all character-formation lie in the Oedipus complex (or earlier component instincts), deep down in those unconscious emotional patterns which were formed, and fixed by repression, during the early years of the person's infancy, when his mind first began to develop emotional attitudes (love, hate and fear) towards persons in his immediate environment, such as parents or parent surrogates. These patterns and their earliest modifications, like all repressed material that is highly charged with emotion, repeat themselves in all subsequent situations throughout the person's life, however inappropriate these situations may be, and without the person having insight into the process. It is as though he were under a compulsion from an unseen force over which he has no control to behave in a certain emotional manner. This behaviour will include not only his symptomatic behaviour, but also his love and sex life, and even his way of thinking and acting in every particular.

Psycho-analysis aims at bringing out the Oedipus complex, and with it all the forgotten period of infantile emotional development, so that the ego will be able to direct it, instead of being directed by it.

Psycho-analysis holds that all methods of treatment which do not go so deeply as to expose the Oedipus complex leave the root of the patient's behaviour untouched, and are therefore at best not permanent cures. The sort of factors with which these other methods deal are at most merely adjunctive or precipitating factors in the causation of the illness. Improvement resulting from these other methods is always incomplete, and often only temporary.

The aim of the psycho-analytical method is to achieve permanent eradication of the very root of the illness, and at the same time to put its psychic energies at the disposal of the ego or reason.

CHAPTER XXXIV

CRITICISM AND FUTURE OUTLOOK

PART I: CRITICISM

THIS enormous psychological structure built up by Freud and the psycho-analysts has been criticised in extraordinary detail by M. Roland Dalbiez in two volumes, which, no doubt, must be a godsend to those who for emotional reasons would welcome such a highly intellectual structure to rationalise and support their biases. It seems to me that there might be some warrant for this criticism if psycho-analysis had set out, as do so many philosophies, to construct deliberately a water-tight logical system, and with no other end in view except the construction of such a system, as an intellectual exercise in sophistry. Then it would obviously be inviting other sophists to join with it in this delightfully stimulating parlour game. M. Dalbiez has made this fundamental mistake in accepting what as a philosopher he has evidently taken to be a challenge. He uses the discoveries of Freud as material for his dialectics and philosophical hair-splittings. Many critics will find much that is praiseworthy in his intricate logical arguments and deductions, but I must confess that I have passed the age when such intellectual games and tricks of the mind take precedence over direct observation of natural phenomena.

the impression that Dalbiez's attempt at assessment from the outside is, however philosophic and scientific, more the criticism of the lack of intellectual, philosophic and scientific *defence work* on the part of the compilers of the psycho-analytical theory, rather than a genuine assessment of the discoveries of psycho-analysis and its inevitably incomplete theoretical structure.

The discoveries and consequent concepts and fundamental theories of psycho-analysis can be re-discovered and proved by the correct application of the technique, and therefore hold true despite any faults in the intellectual defence-work of their exposition. However much such a person as M. Dalbiez may argue against their logicality, he still has his symptoms and irrational instincts, and however much he may prove the illogicality of psycho-analytical construction, the mind still has illogical, primitive mechanisms and they continue to function according to their own illogical laws, and psycho-analytical theory still introduces some rhyme and reason where otherwise all is incomprehensible chaos.

There is, however, another external criticism of psycho-analysis which, though like all our criticisms it can hardly be guaranteed free from some subjective elements, may nevertheless seem to have at least a little justification. How little I shall attempt to indicate after its exposition. It may be stated somewhat as follows:

It commonly happens that when some pioneer, be it in religion, philosophy or psychology, by virtue of his exceptional insight reveals some epoch-making discovery and founds a new religion, philosophy or science, all the lesser people, those with the psychology of followers and not of pioneers, who flock to do homage to the new order, insist upon making it a rigid and unalterable doctrine. Thus we eventually get a *new* reactionism taking the place of the old one which was superseded by the super-progressive who eclipsed it.

What his disciples are the last to see is the fundamental anti-thesis between their psychological make-up and that of the pioneer whose system they stabilise, freeze and endeavour to make sterile. Thus, for instance, Christianity, which was a spiritual and philosophic *advance* upon previous religions, has become for 2000 years a retarding, if not a completely obstructing, influence on future spiritual and philosophic development.

The slightest departure from its Roman interpretation meant torture and death. Similarly, though not quite so rigidly, with Freud's pioneer contribution of psycho-analysis to the frozen and sterile psychologies of the previous epoch. One can understand the charlatan and ignorant critic being debarred, but may question whether the priestliness of the organisation is not an example of that familiar phenomenon of intellectual unconventionality being over-compensated for by some unnecessary rigour and ritual, with the result that the same religious Order is denied fresh impetus and life from independent minds already possessing psycho-analytical erudition. It is perhaps as a result of this human tendency, so contrary to that of the spiritual and intellectual pioneer, that we get in the one case a multiplicity of divergent Orders, denominations and sects, if not creeds, and in the other case divergent analytical systems such as those of Jung, Adler and Reich, not to speak of the multitude of lesser psychotherapies.

This may be inevitable and not in itself so injurious to progress as is the related fact of the exclusion of all revolutionary clinical and intellectual contributions to the stabilised-and-fast-becoming-sterile system.

The majority of Freud's followers today tend to band themselves into an over-rigid constitution from which any mind, however much it may agree to use Freud's discoveries *in toto* as its base and jumping-off ground, which prefers (like Freud preferred) not to be bound and limited by the confines of past discoveries, is ruthlessly excluded from its counsels and figuratively burnt at the stake as a dangerous heretic.

There may be advantages as well as disadvantages in this extreme conservatism, but, to the minds of those offering this criticism, it is not altogether representative of the spirit of science in so far as science must be progressive as well as stable. Foundations, no matter with what increasing security they are being ever-strengthened, are not in themselves enough; there must be progressive building also—even new building on fresh territories. Even occasionally some structures may have to be pulled down and new foundations laid. The progress that is possible without such liberty of action may prove to be so limited that cessation of development, if not inanition, will ultimately ensue. The pioneer spirit cannot be confined within the restricted domain of the pedant if science is to be progressive and worthy of its

name. Enormous unexplored territories remain to be prospected and conquered, including not only the territory of the individual and his mind, but the greater territory of the composite mind of man as a whole, and its objectivisation in the form of his social structure, national and international. Indeed, the entire socio-sphere may well become the province for a truly pioneering psychology with sure scientific foundations.

It may be that there is something to be said for this sort of criticism, but there is a good deal to be said also on the other side. The exponents of modern medicine, based as it is on comparatively recent progress in chemistry, physics, anatomy and physiology, have also found it necessary to band themselves into a rigid constitution to exclude those who would claim to have solved its problems without being even conscious of the existence of the elements of knowledge upon which it is based. Perhaps it too has almost reached its limits within these rigid confines. But even so, it is only likely to accept, and that most reluctantly, expansion (inevitable through the advent of clinical psychology) from those who are already versed in its learning and members of its corporate body. The psycho-analysts are no exception to this general tendency. It may be indicative of life and vitality within the confines of their association that in very recent years the English group since 1945, including the main elements from practically the whole of Europe, has shown less cohesion and has actually disrupted into two or three main groups with increase of individual divergence. At the same time, whatever modifications may be taking place, and however divergent and disruptive some of these modifications may be, the principal foundations as laid down by Freud remain intact and capable of supporting a variety of developing structures.

There is certainly a great deal to be said for the "pure" psycho-analyst who insists upon seeing every case in which he undertakes treatment at least five or six times a week and refuses to be distracted by consultations, extemporary treatments, temptations to effect partial cures, and relatively lucrative expediencies. Perhaps he is in this sense more like a priest than like the business man or more materially-minded colleagues who prefer to deal with immediate "practical" issues. Some of these latter may consider that he has lost his reality sense, in that however greater may be his learning the number of patients

he treats will be incomparably fewer and his income correspondingly smaller.

I am reminded of a great financier and business promoter who, being driven to seek advice on account of marital difficulties, after a few weeks of attendance looked at me with mingled admiration and contempt and said: "Do you mean to say that you spend eight or ten hours a day sitting in that chair earning these paltry fees by your own efforts when, if you let me put you in the way of it, you could make more than your year's income in one deal. Good heavens man! It is you, not me, that must be a bit mad, and you aspire to cure *my* madness!"

Perhaps all science, including both scientific research and applied science, must be a compromise between intellectual pleasure tendencies on the one hand and reality adjustments, such as economic adjustment, on the other. It may be that the psycho-analyst who prefers to see each patient each day at a consequently much-reduced income is merely leaning more to the first extreme, whereas the consulting psychiatrist is leaning to the other. There is place for the psychotherapist between the two. He may in some respects be showing a better adjustment to several realities, including not only that of his material advantage, but also that of his preference for a varied and more stimulating intellectual diet, together with the external reality of the fact that the number of persons requiring treatment far exceeds the supply of therapists, and this disparity would be even more marked if all therapists worked on purely psychoanalytical lines.

The impact of the varied work of a psychological practice, including as it does numerous consultations for doctors, attempts to render help by a variety of means, including sometimes advice, prescriptions of drugs, change of circumstances, symptomatic treatment, a limited number of psycho-analytical sessions, and so on, has its disadvantages as well as its advantages. I have compiled in book form, under the title of *Deep Analysis*, one case history of a complete, or all-but complete, deep analytical study of a single case, but the cases described in the present volume are, for the most part, instances of analytical psychotherapy which do not go so far as a psycho-analytical ideal.

The subjective disadvantages of a full or overflowing programme are particularly inimical to deep analytical work, and when thus pressed and wishing at the same time to ensure the

best and most reliable treatment for a case that was not responding favourably to extemporaneous attempts at environmental adjustment and superficial therapy, I have had resource to transferring the patient to one of the high-priests of pure psycho-analytical technique. For instance, the depressed lady doctor mentioned in Chapter XXV (p. 325): finding as I had expected that the patient was not improving sufficiently by mere recreational advice, and each of us having too full a programme to undertake daily analysis, I was chiefly concerned to *prevent* an analytical situation from developing while I busied myself with the necessary provisions for making such a treatment possible at another's hands. Before daily attendance was practicable her doctor brother would have to be freed from the Services, her practice disposed of and a suitable post found to give her the necessary time, together with the necessary economic foundation. Her depressive tendency to inertia in all matters was such that she could not cope with these preliminary adjustments unaided, while my function in dealing with them, and the contacts with her and her family which these dealings entailed, precluded me to a large extent from the rôle of psycho-analyst. So whilst her natural tendency was to endow me with her transference, my essential function was not only to assess her suitability for psycho-analysis and make the arrangements for her, but especially to circumvent her predilection to use me as her analyst, as progress in this direction might have made the subsequent programme of transfer to another more difficult.

This is just a hint of the various and varied tasks which may befall a psychologist who does not rigorously exclude all patients except those who have been sent to him by another doctor or psychotherapist with the prearranged programme of daily psycho-analytical sessions. I would add that if he allows *too* much variety to creep into his activities, particularly the administration of physical treatment such as injections, shock therapy and so on, he will completely distract his mind from the subjective state essential for the conducting of any sort of analytical treatment.

This brings me to an important part of this chapter. With all this description of technique and insistence upon it, the fact remains that the alleviation of psychogenic disorders is in certain part still as much an art as a scientific process. One has only to be "put out", to have one's own mental equilibrium disturbed,

to be distracted by the slightest worry or extra-psychological interests (such as general medicine), and one's capacity for helping the psychologically sick is immediately, if only temporarily, reduced almost to vanishing point. Therefore one must confess that the first essential instrument of psychotherapy is an absence of anxiety of every sort in the psychotherapist. Patients like children feel the therapist's calm and are better; or they sense his anxiety and are worse.

But while the presence of anxiety is fatal to treatment, its mere absence is not enough, unless of course a mere temporary calming is the limit of one's ambitions. The therapist must be anxiety-free not by dint of "successful" repression of complexes and conflicts, nor by a convenient or gratifying projection of them on to his patient, but by dint of their having been released and dealt with on a conscious plane. In this way only will he be unafraid of the patient's complexes, conflicts and their repercussions. But whatever the explanation, the fact remains that a certain proportion of art creeps into the work and appears to have as much if not more therapeutic effect than the application of scientific instruments. It is not easy to define the process in scientific terms. We may say that intuition and sympathy are two of its essential ingredients. It is difficult to conceive of a patient being helped without their presence in the therapist.

It may be held that the more technique is strictly adhered to the less room does it leave for art, but this, even if true, does not entirely discount the value of the latter. As has been indicated throughout this book, it is not always practicable to subject every case to a rigorous protracted technique, and this for a large number of reality reasons. Therefore in clinical psychology we must not discount altogether the value of the therapist's sympathy, intuition, and personal freedom from worry, conflict and repressions.

He may still require a thorough-going psycho-analytical theory, and more especially technique, as a background or framework for the art of his therapy, but a point I would like to make in passing is that he also requires it as a *defence*. Its defensive value has many facets. To begin with it will help him against the ordinary human tendency, however great a doctor he is, to relieve his personal tensions, under cover of course, at the expense of the patient's welfare, or in some lesser way to infect the patient with his suppressed irritability or other un-

helpful or destructive mood. Again, on the reverse surface, it will help him to defend himself against the patient's affects, and particularly against the patient's tendency to project all unwanted attributes, in short, the disease itself, upon the therapist and paranoiacally endow him with them. Only the analysed therapist will succeed in bearing this cross without at least some disturbance of his beneficent therapeutic mood.

Further, one may say that the more the psychotherapist relinquishes the science of technique in favour of an application of the art of therapy—which latter may mean to a large extent the extemporaneous manipulations of transference—the more he exposes himself to the dangers of psychopathic transferences of patients with inadequate insight and reality sense, particularly to the divergence between the conventional social order and its insistence that he should be an emblem of it on the one hand, and the opposite insistences of the patient's emotional patterns on the other. Thus a strict technique may be regarded as in large part a defence against all the dangers inherent in the therapeutic situation. If we walk through fires, however much they are other people's fires, it may be as well to be clad in asbestos suiting, even if this impedes our movements and efficiency. Psychotherapy is inadequate if it adopts the policy merely of closing all the doors and pretending that there is no fire at all.

PART II: FUTURE OUTLOOK

The real criticism of all therapy must be pragmatic; and here it must be confessed that all forms of treatment, physical as well as psychological, psychological as well as physical, leave much to be desired. In fact, the elaborate and painstaking efforts of medical and psychological science, ranging from an application of all chemical, physical, physiological and anatomical to all psychological, paediatric, sociological, clinical and analytical knowledge, are, from the most superficial to the most fundamental, disappointing in their results. No magical panacea for the ills of the soul has yet been discovered. The attempts to substitute faith for a reality sense are the nearest approach to "magic" in this department; but they cannot be regarded as a panacea, for the policy is short-sighted, amounting as it does to the substitution of delusions or psychosis for dissatisfaction

or psychoneurosis. The enthusiasm of Nazi Germany for its new-found ideal is a good instance of the fallacy of this "psycho-therapeutic" principle—ending, as must end all sacrifices of reality sense, in blood, disease and death. But whatever the psychotherapeutic method adopted, the impression of the clinician and psychopathologist is that it does not wholly eradicate the disease, presumably because it does not reach down to its deepest core, or to its primary aetiological beginnings.

I. METHODS OF THERAPY DIRECTED TO THE SURFACE LEVELS

Alterations of environmental situations and of *actual* conflicts, together with all other superficial readjustments, are effective only in so far as the disturbed personality is fundamentally normal in all respects. Normal personalities are continuously making such adjustments for themselves and for one another without resource to the psychotherapist. In so far as environmental situations or current conflicts are not spontaneously remedied, they are (apart from cases occurring in children) usually indicative of some psychopathic trend in those subject to them, and investigation almost invariably shows that they are indeed nothing more or less than the outward expression of such a trend. That is why therapeutic measures directed at such surface modifications are so extraordinarily rarely of any lasting value.

2. METHODS DIRECTED SPECIFICALLY AT EMOTIONAL LEVELS

Psychogenic illnesses apparently caused (really precipitated) by recent traumatic events, especially such illnesses as war neuroses with amnesia for the events causing them, are almost the only illnesses to which such measures as hypnotism, narco-analysis and other methods directed specifically at emotional levels are at all applicable. But here too results fall infinitely short of those which the inexperienced optimist would expect. Indeed, the uncovering of an amnesia such as this, and the amnesia, however detailed, of a traumatic event, often serve merely to uncover more deep-seated conflict and graver morbid structure. As I have repeatedly shown, especially in *The Analysis of a War Neurosis*¹ and to a lesser extent in Chapter XXXI and in several other cases described in this book, the war trauma,

¹ "Clinical Notes on the Analysis of a War Neurosis", *Brit. J. Med. Psychol.* vol. 19, part 2, and *War in the Mind*, chap. xxiii, 2nd Ed. pp. 188-221.

or other recent traumata, prove themselves to be no more than a precipitating factor in the emergence of psychopathies that have ever-deepening roots. Hence methods directed specifically at uncovering recent emotional levels by such processes as hypnotism and narco-analysis, though they provided at one time renewed hopes for psychotherapists disappointed by the earliest failures to cure by conscious-level efforts, have now proved themselves to be only second to the first methods in ineffectiveness.

- 3. METHODS DESIGNED TO UNCOVER AND SYNTHESISE THE UNCONSCIOUS LEVELS OF THE MIND

Next we come to the third and modern group of psycho-therapeutic endeavours, namely, all methods of *analysis*, particularly deep analysis. These are sufficiently important to have merited my fairly detailed description of the technique and structure of their best-formed member, namely, psycho-analysis. This is perhaps, up to date, the most elaborated and perfected and successful of all the systems. Indeed, in tracing the roots of symptom-formation or of a neurosis or psychosis it has found these roots inextricably intertwined with the nature of the whole personality and going back developmentally practically to the birth of the individual. Surely a method that unravels the entire character—"character" in the McDougall sense of "the sum of the acquired tendencies built up since birth on the basis of the individual's disposition and temperament"—and exposes more or less every ingredient of the individual's infantile amnesia, should, if any psychological method could, be a complete, effective and permanent cure for every form of symptom-manifestation, neurosis, psychosis and psychopathic trend. To the uninformed and inexperienced it would seem amazing that it is not so. But to the experienced clinician and practitioner, particularly if he has taken careful notes of family history, ancestral and collateral, it is amazing that it is even so effective as it proves to be.

4. METHODS OF TREATMENT DIRECTED TO THE BODY AS THE BASIS OF MIND

Is there, then, no absolute cure for psychogenic disorder and its far-reaching repercussions mental, physical and sociological? Must we for ever have wars within the mind and wars within

the nations and between the nations? Surely we might with advantage direct our attention beyond the scope even of psycho-analysis in an attempt to effect still more fundamental levels of the personality.

McDougall defined "temperament" as deeper than "character" in so far as he regarded temperament as "the sum of the effects upon his mental life of the metabolic or chemical changes that are constantly going on in all the tissues of his body"¹—including of course the effects of the ductless glands now recognised to be of such importance. Now we may regard physical methods of treatment as an attempt to produce direct effects through the soma upon McDougall's "temperament". Particularly in the form of endocrine therapy, such treatment might be regarded as reaching to a deeper level than that of psycho-analysis. But the sad fact remains that until we can construct a living human organism synthetically in the laboratory, determining by physical means the exact temperament which we require it to possess, we are, in our physical methods of treatment, interfering with a "machine" which is in all essential respects beyond our comprehension and total control. We are like professing watch-repairers who could not put a watch together. Furthermore, such evidence as we have regarding the finesse of the influences of physical factors upon temperament and character shows that we are more likely to influence both temperament as well as character in an exact, desirable and controlled manner by psychological influences affecting the emotional life than by the direct injection of endocrine products, which endocrine products these emotional experiences should be automatically producing from the inherited glands of the body itself. While psychological influences affect such temperament-bases as endocrine function inadequately, they do at least affect them appropriately, whereas, though physical methods may be adequate, often more than adequate, in their effect, their inappropriateness to psychological-environment adjustments may be truly appalling.

In our present stage of knowledge physical methods of treatment often amount to no more and no less than throwing a spanner into the works of a machine which we do not properly understand. As one of their most modern exponents frankly admits with reference to endocrinology: "Glandular therapy in

¹ McDougall, *Outline of Psychology*, p. 354.

psychiatry is rather the hope of the future than the practical measure of today".¹ I would extend this to a wider generalisation and suggest that while physical methods of treatment may be the future hope, they remain the present holocaust!

5. METHODS DIRECTED TO MAN'S INHERITED DISPOSITION

Thus it will be seen that all these methods of treatment, from the most superficial to the deepest psychological methods, and beyond these to our empirical interferences with the metabolic and chemical changes occurring in the body, are at their best no more than *palliative* measures directed at varying levels of the psychic or somatic structure of the individual, but never reaching to the uttermost roots, which, in some invisible way, are for ever feeding the disease and tending to create it anew.

The clinician, if he takes a very careful family history extending backwards to grandparents and earlier, may acquire a sufficient insight into aetiology to lead to his not being surprised at the inadequacy of all the above methods in their ambitious attempts to eradicate every vestige of illness. He will have accumulated ample evidence to teach him that the psychopathology of even the slightest psychogenic illness goes deeper than the possible application of every therapeutic measure, psychological and physical. He will have seen that not only instinct trends, but even the finest differences of character (in the ordinary sense), show evidence of function passed on (not of course consistently, but by something suggestive of Mendelian laws) through countless generations. The fact that such minute psychological differences are not only heritable, but are actually inherited, shows, I am convinced, that, however acquired, they must have led to some structural alterations, however intangible; and not only this, but that these structural alterations have affected, and been passed on by, the germ plasm.

The conclusion is unavoidable: that to eradicate or permanently transform (*i.e.* cure) the very roots of any psychic disposition or symptom, the therapeutic process would have to begin generations before the birth of the individual. In other words, really effective and permanent cure will require treat-

¹ Sargant and Slater, *An Introduction to Physical Methods of Treatment in Psychiatry*, p. 129.

ment directed not simply at "character" or even "temperament", but right down to "disposition", which in the McDougall sense corresponds to the sum-total of the instinctive qualities determined by heredity. Short of this we can hope only for palliative remedies, even by so far-reaching a therapy as psycho-analysis. The ambitious programme of complete cure, when we shall have abandoned our rudimentary hope of and belief in magic, will have to be extended to at least a form of prophylactic sociology, that is to say, to the creation of a sociological environment which would cease to enhance or encourage disease tendencies.

As the social structure, created as it is by the unanalysed, is and remains nothing more or less than an expression of their mass unconscious including all their unresolved conflicts, it appears to me that the psychopathologist will eventually have to step out of his clinical laboratory and take a hand in reforming the social structure in such a way that it will tend to retard the development of morbid trends and encourage the development of healthful instinct and ego expression. Some may consider on reflection that even such measures could at best be regarded as an expansion of psycho-analytical adjustment from its present individual application to an application to the corporate mind of man, and therefore in this sense still merely palliative, though wider and deeper in its field of treatment. Biologists in particular would hold, like Havelock Ellis, that the effective cure of morbidity will only be achieved by a universal application of the principles of eugenics; but, while far from discarding the theory, I am inclined to regard its ambitious application as analogous on a sociological plane, to that of physical treatment on an individual plane. The morbid combinations of individual healthy trends erupting into psychopathies through the operation of the Mendelian laws of inheritance, are probably so inextricably intertwined through each individual member of the human species that attempts at isolation and sterilisation might prove in practice as clumsy sociologically as are physical methods of treatment individually, though, I would hope, not as ineffective in ultimate results.

On the other hand, a prophylactic sociology analogous, as I believe it would be, on a social plane to psycho-analysis on an individual plane, is to my mind the *natural* method of readjustment. The very fact that leaders of people everywhere tend to

combine in conferences, etc., to create a better world is indicative of the natural operation of this process at work. From the psycho-analyst's point of view the only regret is that they take their unresolved and unconscious conflicts, complexes and biases with them to their various conferences, and no doubt implement or actualise them in their administrative activities. However, it seems that this is all part of a natural process of learning by the painful and bloody experiences of trial and error. I am most emphatically of the opinion that this corpse-strewn journey would be immensely shortened or expedited, and rendered relatively corpse-free, if every such leading executive of the human race were first subjected to an individual psycho-analysis before being permitted to occupy his exalted position.

The philosopher and scientist may have grave fault to find with the foregoing prescription for complete and absolute cure of all psychogenic disorder. The biologist in particular may point out that environmental change, such as sociological improvement, though admittedly affecting the individual and causing him to acquire new and better characteristics, cannot be expected, in keeping with all other acquired characters, to have any effect whatsoever upon his germ plasm and the consequent re-creation at each new birth of the previous psychopathic disposition.

This subject (Lamarckism) is of such outstanding importance that I must ask the favour of being permitted a temporary digression, though I would first insist that its importance is for this present suggestion of *future* psychotherapy, and not for the main subject of this book, and I would ask my critics please to note this distinction, and not to use it as a red herring to divert attention from any inadequacy in their ability to assess clinical psychology as such.

In reference to the much-discredited Lamarckian theory, Stockard found that by administering alcohol to guinea-pigs he was not only able to produce defects in their descendants, but that *these defects were in turn transmitted without the further administration of alcohol*. If therefore germ plasm may be injured, as we know it may be injured, for instance by such toxic agents as the *Treponema pallidum*, and if these injuries can affect subsequent generations, we have *prima facie* evidence of the transmissibility

of "acquired" characters. Admittedly this is not what we ordinarily mean by the inheritance of acquired characters through impingement of environmental stimuli, but strictly speaking internal stimuli, such as alcohol or the *Treponema pallidum*, are nevertheless in the category of chemical environment, the soma being environmental to the germ plasm.

But experiment may have a closer bearing upon the transmissibility of acquired characters in the sense that is most applicable to psychological prophylaxis and cure, if we take such evidences as McDougall's elaborate experiment on the maze behaviour of white rats. To give a few details: McDougall placed rats in a tank from which they could escape by a dimly-illuminated exit. At the same time, he provided another exit more brightly lit which naturally attracted them first, but on their attempting to use this exit they received an electric shock. Half of each litter of rats only was successively subjected to the experiment. He found that whereas untrained rats made an average of 165 errors before learning to avoid the brightly-lit exit which gave them a shock, the offspring of twenty-three successively trained generations of rats made on an average only 25 errors. McDougall believed that this experiment definitely showed some evidence of Lamarckian transmission. Flugel considers that "It may eventually turn out that it will be by this work rather than by any other that McDougall will be best known to posterity".¹

We cannot here enter into the criticisms (e.g. by Crew, 1936) of McDougall's work, but in spite of them one feels that an observer of McDougall's calibre would probably have some grounds for crediting his observations and conclusions. Even so strong an anti-Lamarckian as Huxley admits that some experiments (e.g. those of Metalnikov, 1924, and of Sladden and Hewer, 1938) demanding a Lamarckian explanation "have not yet been discredited".²

W. H. Harrison's (1927) studies of the saw-fly, whose larvae produce galls on willow, provided modern experimental evidence in favour of Lamarckism despite Thorpe's subsequent demonstration that the egg-laying preferences for different species of willow by different races of this fly are determined by an olfactory stimulus and that "mutations", suitable to the environ-

¹ J. C. Flugel, *One Hundred Years of Psychology*, p. 278.

² Julian Huxley, *Evolution* (1944), p. 459.

ment thus chosen, will therefore be selected and incorporated.¹

C. S. Myers² reminds us that "David Katz (in his *Animals and Men: Studies in Comparative Psychology*, 1937, p. 245) quotes an example from K. Friedrich, where a change of appetite was experimentally produced in the caterpillar *Lasiocampa quercus*, whose natural diet is the oak. Some of these caterpillars, when transferred to the Scots pine, succeeded in using the needles of the latter as food, although many others died. Those who succeeded 'achieved this by attacking from the tip, as the needle is too thick to be spanned by their jaws. The second generation ate the pine needles without difficulty; they were adapted to them and thenceforth incapable of returning to oak leaves, which they attacked from the tips although they normally eat from the edges.' " Characteristic of the fear biologists have of supporting Lamarckism, David Katz refers to these obvious examples of the inheritance of acquired characters as "something like mutations of instinct"!

The Hymenoptera are supposed to provide the final knock-out blow to Lamarckism in that the workers are neuter females and all reproduction is confined to the "queen" and "drones". There are two possible answers on behalf of Lamarckism: one is that such organisations have become, for this very reason, no longer racially adaptable, that evolution has in their case come to a standstill, having reached the limit of specialisation and stabilisation. The other is that though the "queen" and "drones" are the sole bearers of the germ cells, these creatures are constantly being influenced by the workers in the type of environment provided for them, particularly in the type of nutritive environment, in the same way as the testes and ovaries of other living organisms are influenced (cf. for instance Stockard's experiments with alcohol, p. 463).

At one time Pavlov believed he had found evidence of the inheritance of his conditioned reflexes, though it seems that later he doubted his own observations. Kamerer's work on the

¹ Harrison took a race of saw-fly which was normally confined to the willow *Salix andersoniana* and for four years kept it on *Salix rubra*. Its mortality particularly in the first generation was considerable, and its survival is said to have been only at the expense of those who were "genetically best adapted to the old host" (*Huxley's Evolution*, 1944, p. 304). Then for three years Harrison allowed this saw-fly to have access to both species of willow. The Lamarckian point is that it remained true to the acquired adaptation to *Salix rubra*, showing that it had not only acquired that adaptation but that the new racial characteristic was transmitted.

² C. S. Myers, *British Journal of Psychology*, General Section, September 1943, p. 4.

transmission of acquired protective colouring appears more credible, despite the usual criticism. In this connection it seems to my unbiological mind that the universally evident fact that races whose ancestral life has been lived in the tropics, on emigrating to the temperate zones nevertheless continue to reproduce dark-skinned offspring, is itself far stronger evidence of the inheritance of acquired characters than it is evidence in favour of the opposite contention. Seeing that all humanity is of the same species, we may well ask how it came about that those habitually living in the tropical zone acquired a pigment under the skin lacking to those in more temperate regions. The answer is obvious (in spite of the obscurantism of the biologists with their exaltation of such secondary evolutionary processes as Mendelian genes, mutations and natural selection to a position of primary importance), and the fact that they transmit this acquired character at least for some generations when removed from their native habitat is evidence of the transmission of it. The further fact that lighter-skinned people begin to acquire at least some degree of this pigment when exposed to tropical light rays *shows us the process whereby this character became acquired.* The further fact that it is not transmitted to the offspring of these sun-bronzed white races merely suggests to us that as a general rule environment must be perpetuated through many generations for the changes effected by it to become transmissible.

Even so orthodox a scientist as C. S. Myers has as recently as while I am writing (September 1945) admitted: "There are not a few who think that sufficiently prolonged genetic research is in time likely somehow to bridge the present apparently impassable gulf between Lamarckism and neo-Darwinism. Without *some* form of Lamarckism, it is hard to understand the evolution of mind, including that of instincts. The closer study of instincts may enable us to determine whether instincts are merely and always the outcome of chance variations in the germ plasm, perpetuated *ab initio* by heredity and by the operation of natural selection; or whether they have not also been evoked by the interests, needs and efforts of the organism itself, assisted by, if not also assisting, inheritable changes in the germ plasm."¹

I am convinced that the failure of biologists to see the essential

¹ C. S. Myers, *British Journal of Psychology*, General Section, September 1945, p. 3.

truth of Lamarckism and their insistence on the counter-claims of mutations and natural selection, is an instance of the common occurrence of scientists being so taken up with the *mechanism* that they fail to see the general principle, and is also due to a more fundamental failure on their part to see the "identity" of organism and environment together with the "identity" of individual and species. Only thus could they discount the obvious fact that adaptation to environment is the essential condition for the continuance of life, the essential characteristic of living matter, and the essential element in the evolutionary process—a process which is nothing more or less than an extension of the principle of adaptation, and its application to the species as a whole. I am convinced that if environment did not affect living organisms in a more than temporary, individual manner, affecting at the most merely changes in the somatoplasm and leaving hereditary proclivities totally unaffected, there would be no such process as evolution with its essential ingredient of adaptation to environment.

Admittedly germ-plasm changes may lag behind, possibly generations behind, somatic alterations in function and in structure, and the anti-Lamarckian experiments of biology have proved nothing more than this. On the other hand the whole biosphere and the highest product of the earliest stages of its evolutionary process, namely man and his mind, are conclusive evidence of a world-wide "experiment" proving nothing more or less than the inheritance of acquired characters, however complicated and indirect (e.g. via mutations) may be the processes whereby these changes are transmitted.

Therefore to my mind the therapeutic measure necessary to eradicate the very core of all neuropathies and psychopathies must be nothing more or less than a measure directed to man's disposition—in the McDougall sense of "the sum of the instinctive qualities determined by heredity". Such a measure requires as its therapeutic "instrument", or "system", an alteration in man's environment, particularly in his sociological environment, an alteration to which the psycho-analyst will have to contribute a very important part.

Why the psycho-analyst? Who but the psycho-analyst would recognise that the matter of supreme importance in sociological prophylaxis is *perfect service to the new-born babe!* Who but the psycho-analyst would recognise further that perfect service at

prescribed by scientific knowledge, however perfect, can never be perfect enough! Could love-making be perfect if inspired simply by the reading of a scientific treatise on the subject, even by the memorising of all Havelock Ellis's nine or nineteen volumes? The baby-tenders will have to *feel* the inspiration for their care from their own healthy instinct sources to execute it correctly. No knowledge can take the place of this, but knowledge, particularly insight, can act as a useful guide for love and a necessary deterrent for hate.

Only the psychologist will be adequately aware of the importance of the *avoidance of all traumata*, and then only the analysed psychologist¹ who has also analysed patients and actually seen in practice the effects of such traumata. I am reminded of an incident in the late war when I had occasion to go to a village which was rumoured to have received a flying bomb some three nights previously. Seeing no sign of damage, I asked a native where the bomb had fallen. He said in a field two miles to the west. I told him the rumour and asked him if the explosion had been loud. He, not knowing I was a doctor, replied irascibly, "Loud enough to give my two-months-old baby diarrhoea ever since." While the psychopathology of adults causes the dropping of bombs, their psychopathies shall be visited upon the children unto the third and fourth generation.

Psychologists recognise similarly that the quarrellings and other *emotional displays*, including sexual, of parents, even without the addenda of high explosives, also disrupt the foundations of security in the child and substitute anxiety for health.

A hundred and one other sociological reforms affecting the emotional basis of life from the cradle to the grave, reforms which are likely to occur primarily to the mind of the psychologist, crowd in upon the imagination, but are hardly appropriate for exhaustive treatment in this present work. I shall refer only to a few in chronological extension of those already mentioned.

The psycho-analyst will wish to revolutionise the whole system

¹ In case of misunderstanding I must here stress that I have used the terms "psychologist" and "psycho-analyst" to denote an exhaustively, if not fully, analysed person and not one of those practitioners who actualises his conflicts and deals with them by proxy of his patients instead of subjecting himself to treatment. Such "psychologists" are commonly even more prone than the average unanalysed person to biases and jealousies and to the familiar projection of their complexes to create as mad an actuality as exists in the unconscious mind of us all.

of *education* so that the child is no longer stuffed with uninteresting and useless knowledge (*e.g.* Latin), which he does not want and which is bad for him in any case, until he has acquired a revulsion from all learning and is taught chiefly to put up and perpetuate a resistance against it. On the contrary, all his natural curiosities and interests will be gratified, thereby increasing his intellectual appetite without limit, instead of spoiling it irrevocably.

No person other than a clinical psychologist is likely to assess adequately the injurious effects of the socially and economically based inevitable maladjustment, or absence of adjustment, of the *post-pubertal and adolescent life* of all persons, whether or not the resulting stresses manifest themselves in neuroses, psychoses or merely in the usual morbid character formations and their expression in further sociological morbidities.

Who but the clinical psychologist will appreciate adequately that the vast majority of people, women as well as men, in trying to adapt their already injured sexuality to the social edict of *matrimony*, experience at the best a succession of partial failures, the revenue of which is extracted in the form of nervous strain, psychoneurotic symptoms and morbid character traits!

Who but the psycho-analyst will have full insight into the fact that all *patterns of culture* are but the externalised equivalents of man's unconscious mind; and that conventions, customs and institutions represent and perpetuate all that is stupidest and most injurious in primitive thinking; and that our criminal *laws* (advisedly so designated!) vivify and execute a savagery of which no individual civilised person would otherwise be capable!

Who but the psycho-analysts would recognise—and I am not sure that they and other psychologists (except me) do recognise—that *feeling*, emotion, is the essence of life; and, divested of this and its mental basis in phantasy and perhaps delusion, life becomes a meaningless misery, a melancholia, and must perish as surely from internal, subjective mental causes, as the unfettered expression of emotion on a large or national scale must destroy it by external, objective physical causes—a statement which may now be underlined since the destructive utilisation of atomic energy!

So long as the individual aspires to pure reason, so long will his repressed emotions erupt to form neurotic symptoms or disabilities, and, so long as the social structure is a dramatisation

of these impractical aspirations and the resulting conflict, so long will humanity suffer massively as well as individually.

The failure of society to compromise between the rival claims of emotion and reason is, like the simpler individual failure, the cause of almost all conflict and its disastrous consequences, and on the sociological plane is responsible for the extravaganzas of religion and war on the one hand and the moribundities of effete over-civilisation and a falling birth-rate on the other.

Thus we see that the new "prophylactic" social order cannot be the obvious "cold" product of cold reasoning as the non-psychologically-minded reformer would try to make it, for such a heaven of frozen sterility would have little advantage over a hell of burning passion. Have we no alternative to the rival programmes of perishing in the solar fires of atomic explosions or freezing in the refrigerator of an emotionless life? Oh, for the time and ability to compile the new philosophy which must emerge from an unbiased study of the hidden nature of life and mind, as surely as the new physics emerges from the discovery of the hidden nature of matter!

In the meantime this much is clear: the necessary prophylactic alterations in our social structure will have to receive some contribution from psychopathology; and only when these alterations have been perpetuated through countless generations will there come about, gradually and progressively and through a Lamarckian process of evolution, a condition which we would today regard as a complete cure, primarily of the diseased, corporate body of man, and secondarily of us, more or less diseased individuals who comprise the indivisible portions of that body, all individual sufferers from a generalised psycho-genic morbidity.

GLOSSARY

ABREACTION. The re-experiencing of repressed emotional tension.

ADDISON'S DISEASE. A disease of the suprarenal glands, usually tubercular, characterised by extreme weakness, anaemia, wasting, very low blood pressure and bronze pigmentation of the skin and mucous membranes.

ADRENALS. Adrenal glands, also known as suprarenal glands, capsules or bodies, are two small organs situated one upon the upper end of each kidney. The medulla of the glands produces adrenaline, a substance which stimulates the sympathetic nervous system and the output of sugar from the stored glycogen (starch) of the liver. The cortex of the glands produces cortin which seems to control the metabolism of sodium, of chlorides and of carbohydrates, and is also concerned with sexual physiology. It is essential to life.

AETIOLOGY. The science of causation.

AFFECT. The energy of an emotion. It may be aroused by a variety of stimuli and is capable of displacement on to concepts with which it was not originally associated.

AMBIVALENCE. The simultaneous existence of opposing affects, usually love and hate, directed towards the same person or object. One or both of the affects may be unconscious.

AMENORRHOEA. The absence of the menstrual flow during the time of life at which it should be present.

AMNESIA. A memory blank.

ANAL EROTISM. Pleasurable sensations experienced through the act of defecation, or other stimulation of the anus, especially enjoyed in childhood and repressed later.

ANAL SADISM. The aggressive instinctual quality associated with the anal function, and apparently an extension and elaboration of the earlier oral sadism expressed in the biting instinct. It seems that the infant controls and ejects its auto-erotic anal "world"—and thence the outer world—with an omnipotent, aggressive quality.

ANALYST. One who is being treated by analysis.

ANOREXIA NERVOSA. Loss of appetite from emotional disturbance, often leading to extreme emaciation, and curable by psychotherapy.

ANTI-CATHEXIS. The shifting of an emotional charge (cathexis) associated with one impulse on to an impulse of an opposite character. For instance, an original emotional interest in soiling or dirtying may become an interest, often excessive, in cleanliness; and unconscious hate may appear as conscious love.

APHASIA. A loss of ability, due to a cerebral lesion, to pronounce words, or to connect correctly words and their meaning.

APNOEA. Cessation of breathing.

ARTIFACT. An artificial product.

AUTO-EROTISM. Self-generated erotic stimulation without resort to another person.

AUTOMATISM. Automatic activity, i.e. activity without conscious knowledge thereof.

AUTONOMIC NERVOUS SYSTEM. A complex system of nerve fibres and ganglia (comprising the somewhat antithetical sympathetic and parasympathetic motor nervous systems) which exists all over the body, chiefly outside the central nervous system, and which acts in a self-regulating way, independent of voluntary control, but reacting to emotion, and supplying the glands, viscera and involuntary muscles with their regulating stimuli.

BABINSKI'S REFLEX. The name applied to an abnormal response of the plantar reflex. When a body is drawn along the outer part of the sole of the foot, instead of the toes bending down as they normally do, the great toe bends upwards.

BIOGENESIS. The origin of life (vegetable or animal) from living matter; the doctrine that living organisms can spring only from living parents.

BIOGENIC PSYCHOSIS. The conception originated with Kraepelin, who differentiated by the term "dementia praecox" a class of reactions which he supposed to run a dementing course. Craig and Beaton regard the biogenic psychoses as those resulting from abnormal reactions to experiences which should normally build up the personality, and as having no other cause than the patients' failure to master life. In the light of family histories I would like to extend this to include hereditary predispositions with Lamarckian implications. The psychoses known as biogenic are dementia praecox, dementia paranoides, paraphrenia, paranoia, manic-depressive psychosis and the involutional states.

BIOSPHERE. The sphere of living organisms, both plants and animals. Prof. Sir J. Arthur Thompson recognises three great "Orders of Facts": the CosmospHERE of non-living forces and things, the Biosphere of living organisms and the Sociosphere of human societary forces acting as units.

CASTRATION. Removal of the organs of generation.

CATALEPSY. A condition of stupor with tense muscles or *cerea flexibilitas* (wax-like flexibility).

CATATONIA. A mental disorder characterised by alternating stupor, catalepsy and occasional outbursts of activity. A symptom complex of dementia praecox.

CATATONIC FRENZY. The frenzied activity of catatonia.

CATATONIC RIGIDITY. The muscular rigidity of catatonia.

CATHARSIS. Discharge of emotional tension by bringing it to consciousness.

CATHEXIS. A charge of emotional energy investing an idea or object.

CEREBRAL DYSRHYTHMIA. Abnormal rhythm in the record of electrical activity in the cortex of the brain as shown by the electro-encephalogram. It is characteristic of a majority of epileptics. It is said to exist, as a non-specific type of dysrhythmia, in as many as 10 per cent. of the population and interestingly increases as severer degrees of constitutional psychiatric abnormalities are approached. (Sargant and Slater.)

- CLINICAL** Originally of or pertaining to the sick bed and hence to do with observation of the actual patient, as distinct from theoretical constructions
- CLONIC MOVEMENTS.** Short spasmodic movements
- COMPLEX** A group of affectively charged ideas which, through conflict, have become repressed into the unconscious
- CONATION** The conscious tendency to action. Affect, whether associated with cognition (perception, ideas and reason) or not, leads to conation
- CONFLICT** "War" between opposing elements in the mind
- CONVERSION HYSTERIA** When mental conflict, usually unconscious, in an individual whose libido has reached a genital level of organisation, gains expression by means of physical symptoms, the condition is known as conversion hysteria
- COSMOSPHERE** The sphere of non living forces and things (Cf BIOSPHERE, above)
- CRETINISM** A condition due to thyroid deficiency, congenital or in early life, resulting in feeble-mindedness, retarded growth and typical mal-development
- CYCLOTHYMIA** A condition characterised by recurring phases of elation and depression, its extreme form being manic-depressive psychosis
- DEATH INSTINCT** According to Freud, a deeply rooted instinctual impulse that serves to take the organism back as far as possible to its original inorganic state. It is supposed to be closely associated with destructive, aggressive and repetitive tendencies in the psyche, and to contrast with the "life" or libidinal instinct
- DECEREBRATE RIGIDITY** A form of muscular rigidity, due to spinal reflex action, when this is no longer inhibited by impulses from the cerebrum (brain) owing to the latter's destruction or severance
- DEFENCE RESISTANCE** All contrivances, conscious and unconscious, employed by a person to avoid insight into his motivations, or specifically by an analysand to retard the progress of his analysis
- DEMENTIA PRAECOX** or SCHIZOPHRENIA. A psychosis usually appearing before middle life and characterised by introversion, repressed affect and interest, resulting in a splitting or dissociation of the internal life from appropriate reaction to and cognisance of reality
- DESOCYCLOCORTICOSTEROIDE** A synthetic chemical compound having the same action as "cortin", the extract of the cortex of the suprarenal gland. It has been used in the treatment of Addison's disease.
- DETUMESCENCE**. Subsidence from swelling. A term much used by Havelock Ellis to denote what he calls the second part of physiological sexual activity. The first part, tumescence or becoming tumid, is followed, with or without orgasm, by a comparatively rapid subsidence of the tumidity with decline in excitation.
- DURPLACEMENT**. The transfer of an affect from the idea to which it was originally attached to an associated idea. It is one of the most important unconscious mechanisms in the production of phobias and other symptoms.
- DISCHAMA**. A diseased constitution.

DYSMENORRHOEA. Painful menstruation.

ECHOPRAXIA. Meaningless imitation of gestures or movements made by others. It occurs as a symptom of dementia praecox.

EGO. That part of the id which has become modified by the impingement of external stimuli in such a way that it has become adapted to reality, reality testing and activity, and is credited with consciousness. In contradistinction to the id, it tends to organisation into a united whole.

EGO HYPOCRISY. A term invented to stigmatise the hypocritical ego-tendency to pretend that that which conflicts with its wishes is non-existent.

EGO RESISTANCE. Resistance to insight, or to analytical progress, emanating from the ego or conscious levels of the mind.

EGO-SYNTONIC. Fitting into the harmony of the ego and thus acceptable by it and helping to integrate it or build it up.

EJACULATIO PRAECOX. A premature ejaculation of semen previous to, or at the beginning of coitus, and thus circumventing full orgasmic satisfaction.

ELECTRIC SHOCK TREATMENT or ELECTRIC CONVULSIVE THERAPY ("E.C.T." for short). Treatment by means of an apparatus of passing a measured electric current (*e.g.* 130 volts for 0.3 of a second) through the frontal lobes of the brain and thus producing an epileptiform fit.

ELECTRO-ENCEPHALOGRAPH. The apparatus by which the regular rhythmical change of electric potential in the brain, due to the rhythmic discharge of energy by nerve cells, can be recorded.

EMBOLISM. The plugging of a blood vessel by some material, usually a blood clot, which has been carried through the larger vessels by the blood stream.

ENDOCRINOLOGY. The science which is concerned with ductless-gland secretions and the autonomic nervous system.

ENDO-PSYCHIC PHANTASY. Phantasy having its origin within the psyche, that is, not activated by any external stimulus, somatic or environmental.

EPINOSIC GAIN MOTIVE. The secondary or superimposed gain which may, consciously or unconsciously, act as a motive in determining the form of an illness or in maintaining it.

EROTIC. Sexual.

EROTOGENIC ZONES. Sensitive areas of the body stimulation of which gives rise to erotic feelings. These areas are often where mucous membranes join skin at the bodily orifices.

EUPHORIA. A sense of well-being, usually morbid or abnormal.

EXTRAVERT. One who turns his interests outward and experiences his emotional life in relation to the stimuli of the external world.

FARADIC ELECTRIC BRUSH. A wire brush through which a Faradic, or induction coil make-and-break, current is passed. It is used to cause powerful, though harmless, electric stimulation to an hysterically insensitive part.

FETISH. Anything which is attractive on account of its association, usually through unconscious elements, with erotic pleasure.

FIXATION Arrest of a portion of the libidinal stream at an immature stage of development, either with reference to its erotogenic zone or with reference to its object attachment or both. The level of a fixation determines the type of any psychosis or psychoneurosis which later may occur, and the nature of its object attachment may determine its presenting form.

FRUSTRATION The action of frustrating, or an obstacle or force which stands in the way of gratification or of the aim of an instinct.

GENES Hypothetical units attached to the chromosomes, each supposed to determine a special hereditary characteristic.

GENETICS That portion of the science of biology which seeks to account for the inherited resemblances and differences in organisms.

GENITAL ORGANISATION That mature stage of libidinal development when the component instincts have become synthesised with genital primacy and full capacity for object love. In infancy it gives rise to the Oedipus complex and in later life to psychosexual union.

GONADS The generative organs, either ovaries or testicles.

HALLUCINATION A false sensory perception referred to one of the special sense organs as of hearing, sight, smell, etc.

HEBEPHRENIA A type of dementia praecox showing a tendency to simple extreme introversion with withdrawal from the external world, and often exhibiting such manifestations as smiling, laughter, grimacing and mannerisms in speech and action.

HETEROSEXUALITY Love for or erotic interest in a person of the opposite sex, i.e. normal psychosexual development.

HOMOSEXUALITY Sexual desire for a member of the same sex.

HYDROCEPHALUS The term applied to two different diseases of the brain, both of which are characterised by effusion of fluid into its cavities. These are acute and chronic hydrocephalus.

HYPERPLASIA An abnormal increase in the number of cells in a tissue.

HYPERTONUS A state of increased tension, as of a muscle in a condition of tonic spasm.

HYPNAGOGIC STATE A state between sleeping and awakening.

HYPNOTISM The theory and practice of inducing by psychological means a state resembling sleep.

HYPNOCHONDRIA or **HYPNOCHONDRIASIS**. A condition of morbid anxiety about the health, in which various healthy organs are believed to be diseased.

HYPOGLYCAEMIA The term applied to a condition in which there is a sub-normal quantity of sugar in the blood. It may occur in states of starvation or after the administration of insulin in large doses.

HYSTERIA A psychoneurotic disorder resulting from a conflict between the libido, including non-genital organisation thereof, and the ego or super-ego, in which the libidinal drives are repressed and thus excluded from direct or conscious expression and in which the unconscious repressed material later, through displacement and conversion, finds an outlet by an indirect somatic pathway and thus produces symptoms. Freud describes two principal varieties: (1) anxiety hysteria, in which

the predominating symptom is anxiety but distinguishable from anxiety neurosis in that the aetiological factors are psychological (such as infantile sexual traumata) rather than physical (e.g. disturbances in the current sex life); and (2) conversion hysteria, in which the principal symptoms are physical (hysterical pains, paralyses, etc.). Fixation hysteria is a less important concept applied sometimes to cases where the form or locus of the symptom has been strongly determined by some external factor, e.g. by a wound or physical illness.

HYSTERICAL CONVERSION. See **CONVERSION HYSTERIA.**

ID. The concept of an undifferentiated primitive mind containing only innate urges, instincts, desires and wishes without consciousness or any appreciation of reality, and apparently dominated by the pleasure principle. Unlike the ego it is not organised or integrated, so that contrary and incompatible urges can exist side by side in it without necessarily entering into conflict with each other.

ID RESISTANCE. Resistance to analytical progress emanating from the id, usually due to the energy of the repetitive instinct, or to a disinclination to permit modification of pleasure-giving instinct patterns.

IDIOPATHIC EPILEPSY. A condition in which the main or only symptom is the occurrence of epileptic fits *without discoverable cause*. To be distinguished from symptomatic epilepsy in which the fits are secondary to some organic disorder or disease, such as cerebral injury or toxic agent.

IMAGO. The fantastic image formed in infancy from an erroneous conception of a loved or hated person.

INFANTILE AMNESIA. Refers to the memory blank which evidently obscures the adult's recollection of certain early periods of his infancy. It does not imply its literal meaning of memory blanks occurring *in* infancy.

INFANTILE TRAUMATA. Injuries to the psyche sustained during infancy. These are largely of a sexual nature, but any overdose of emotional experience—such as a severe beating—can cause a psychic trauma, especially in infancy.

INHIBITION. Restraint or frustration of an impulse by an opposing force, usually by an intra-psychic force. A frustration from within the psyche.

INSTINCTS. Innate patterns of discharge of tension.

INTRA-PSYCHIC. Within the mind.

INTROJECTION. A mental process by which one identifies himself with another person or object incorporating it into his ego-system, so that the previous object-cathexis is transferred to a portion of his ego and this brings about a profound change in the intra-psychic libidinal situation. It is a process of assimilation of the object and of feelings associated to it; whereas "projection" is a process of dissimilation.

INTROVERSION. The reversal of the libidinal stream from outward-seeking to inward-absorption, with consequent withdrawal of interest from the external world to the internal world of self. When extreme in degree it is one of the characteristics of schizophrenia, melancholia, hypochondriasis, etc.

INVERSION. (Sexual inversion.) A condition of the sexual instinct being turned to persons in the image of oneself or of one's parent of the same

sex as oneself, homosexuality Havelock Ellis uses the term in a special sense to imply "inborn" constitutional abnormality towards persons of the same sex It is thus a narrower term than "homosexuality, which includes all sexual attractions between persons of the same sex, even when seemingly due to the accidental absence of the natural objects of sexual attraction, a phenomenon of wide occurrence among all human races and among most of the higher animals" (Havelock Ellis, *Studies in the Psychology of Sex*, vol 2, p 1) "Inversion" is not generally used in this restricted sense but more commonly as a synonym for homosexuality

INVOLUNTIONAL MELANCHOLIA A psychosis occurring between the ages of 45 and 60, and supposed to be due to the beginning of the retrograde biological changes of senility, or of endocrine readjustment, as at the menopause It is characterised by despondency, delusions of self-unworthiness, agitation and suicidal tendency

LATENCY PERIOD Period of life between the hypothetical end of infantile sexuality and the beginning of pubertal sexuality

LESION Originally meaning an injury, but now applied generally to all morbid changes in organs and tissues

LEUCOTOMY The operation of cutting the white nerve fibres (See PRE-FRONTAL LEUCOTOMY)

LIBIDINAL FIXATION or LIBIDO FIXATION The retention of a portion of the libido at an early level of psychic growth, commonly with special reference to some particular erotogenic zone (e.g. anal fixation) or to some early object attachment (e.g. mother fixation)

LIBIDINAL ORGANISATION The emotional pattern or system of sequences assumed by the libido The libido passes through many stages in the course of development From oral to genital the component instincts all have their own organisation or pattern, but full maturity is reached only at the genital level of libidinal organisation with its whole-object (persons as such) relationship

LIBIDO The energy of the sexual instinct and of its psychosexual component instincts It is subject to many vicissitudes For example, it can become aim inhibited (i.e. orgasm inhibited) and undergo unlimited displacement, even on to the person's own ego (narcissism, self love), asexual objects and abstract ideas

MANIC Pertaining to mania, or the exalted phase of manic-depressive psychosis

MANIC-DEPRESSIVE PSYCHOSIS A well-defined psychosis of the affective group characterised by (1) elation with over activity, or (2) depression with psychomotor retardation, or (3) mixed forms It usually remits, though chronic states can supervene, and it is not so prone to lead to dementia as are other psychoses.

MASOCISM A perversion in which sexual excitement is accompanied by the wish to be physically subdued and hurt It is the converse of sadism, the perversion in which sexual pleasure is obtained by masters g., subduing or inflicting pain The two are closely related, the former being more feminine, the latter more masculine

CLINICAL PSYCHOLOGY

MASTURBATION. The act of producing sexual feeling by manual manipulation of one's own genital organ or other erotogenic zone.

METHEDRINE. A recently elaborated chemical stimulant very like benzidine in its effects.

MESMERISM. Hypnotism. So named on account of its introduction by Mesmer in Vienna about 1775.

MYXOEDEMA. A disease due to a deficiency of thyroid secretion (from disease or atrophy of the thyroid gland) originating in adult life (cf. CRETINISM) and characterised by retardation of metabolic and mental activity, changes in the connective tissue and characteristic obesity, dryness of the skin and alopecia.

NARCISSISM. Love of oneself.

NARCO-ANALYSIS. The attempt to obtain unconscious or suppressed mental material from a patient by the aid of narcotics.

NARCO-HYPNOSIS. The attempt to produce an hypnotic condition in a patient, by means of narcotics, for analytical or suggestive purposes.

NARCOLEPSY. Short, compulsory attacks of sleep which the subject is unable to control. The term is also applied to short attacks of muscular weakness in which the subject falls to the ground without loss of consciousness.

NARCOSIS. State of being under the influence of a narcotic drug.

NEUROLOGY. The science of organic disease of the brain and nervous system.

NEUROSIS. A functional nervous disorder. By some writers used to designate any psychogenic illness.

OBSSESSIONAL NEUROSIS. A psychoneurosis characterised by the presence of obsessions which dominate the thought processes and behaviour of the patient. Compulsion neurosis.

OCULOGYRIC CRISES. Attacks in which there is a forced upward deviation of the eyes with head retraction lasting for half an hour or so and causing some distress. It is a special form of post-encephalitic Parkinsonianism.

OEDIPUS COMPLEX. As in the play (*Oedipus Rex*) by Sophocles, and as in the Greek legend on which it is founded, the unconscious of man from which these dramatisations originated, has been shown by psychoanalysis to contain a repressed constellation comprising a desire to displace the parent of the same sex and to possess sexually the parent of the opposite sex. It is something infinitely more powerful than common sense that comes into effective conflict with the Oedipus constellation. It is specifically fear of castration which causes total repression of these desires and phantasies. Amongst the evidences of this repression there are the normal horror of incest, intimacy with the very person with whom one had since birth or before birth been most intimate, and the normal tendency to dramatise the repressed constellation in actuality, through the mechanism of displacement, by marrying a person in the image of the repressed imago, and the persistence, at least in physical form, of a repugnance for those in the image of the once hated or displaced parent. Inability to deal adequately in these normal ways with the energy of the repressed complex and consequent regression to fixa-

tions at pre Oedipus levels of libidinal organisation, are the nuclear bases of psychoneurotic, characterological and mental disorders

OEDIPUS FIXATION Libidinal fixation to the emotional pattern of the Oedipus complex, with or without change of object

OESTRIN A common trade name for oestrone, a pure crystalline excretion product of the ovarian follicular hormone, oestradiol, extracted from pregnancy urine. Its administration has various effects upon metabolism, especially upon the menopausal syndrome

ONTOGENESIS Development of the individual

OOSPERM A fertilised ovum (or female "seed")

OPHTHALMOSCOPE MIRROR A little concave mirror used for examination of the eye

ORAL EROTISM Erotic excitation from stimulation of the mouth or lips, the primary source of erotic feelings in babyhood and continuing in variable degree throughout life in spite of the acquisition of genital maturity with which it becomes associated, as evidenced by the phenomena of kissing and various habits and perversions

ORGASM The point at which erotic excitement reaches its acme and becomes involuntary. On the latter account it is suppressed by most persons in proportion to their prevailing anxiety and ill health

ORGASTIC POTENCY The degree of capacity to achieve "perfect" orgasm, that is to say an orgasm which will result in complete reduction of sexual tension and at the same time satisfy the whole psyche, i.e. without residual disturbance or conflict

ORIFICE An opening or aperture, usually where the mucous membrane, the lining of the body's internal channels, joins the skin or external covering

PANCREAS A long glandular secreting organ situated transversely behind the stomach. It has two distinct varieties of secretion (1) the pancreatic juice, the most important of the digestive juices, which it pours into the small intestine, and (2) insulin, a ductless gland secretion absorbed directly into the blood stream, and controlling sugar metabolism

PARAESTHESIA Disordered sensation

PARANOIA A psychosis characterised by systematised delusions commonly of persecution, love or hate. Freud considers that it has its source in repressed (unconscious) homosexual desires

PARAPHRENIA A psychosis, lying between paranoia and dementia praecox and characterised largely by disordered sensations, with delusions less well organised than those of paranoia but with little disorder of behaviour. Freud uses this term instead of dementia praecox.

PARENT SURROGATE A substitute for the parent, often not recognised as such

PARESIS Weakness of a muscle or group of muscles not amounting to complete paralysia

PART-OBJECTS Anatomical parts of a person which may be objects of intense love or hate without reference to the person as a whole. For instance, the baby loves the breast or nipple (a part object) without necessarily his mother as a 'whole-object'. The persistence of this tendency into adult life is a measure of various libidinal fixations.

PELLAGRA. A vitamin-deficiency disease, rarely seen in Britain, characterised by serious disturbances such as tremors, weakness, irritability, headache, depression, delirium, digestive disturbances, and redness, bronzing and roughness of the skin of the face and hands or other exposed parts.

PERCEPTUAL CONSCIOUS. The spear-head of consciousness. That portion of consciousness which is momentarily the focus of the attention.

PERIPHERAL NEURITIS. Inflammation of those portions of the nerve fibres which are most distinct from the central nervous system.

PERVERSION. Any sexual act the object or mechanism of which is both biologically unsound and socially disapproved. Perversions are usually the manifestation of a psychosexual component instinct in substitution for mature genital sexuality.

PHALLIC. Pertaining to the phallus, the erect penis or its image, worshipped in some religious systems as symbolising generative power in Nature.

PHOBIA. Morbid or unjustifiable fear, e.g. of some harmless object, activity or situation. It is unconsciously associated with some repressed and feared instinct desire.

PHYLOGENESIS. Biogenic development or evolution, e.g. of race or species. (Cf. ONTOGENESIS: the development of the individual.)

PITUITARY. A small glandular structure no bigger than a pea attached to the base of the brain. It has four parts and many functions, including that of presiding over growth and sexual development.

PLANTAR FLEXOR RESPONSE. The normal reflex action produced by stroking the outer side of the sole of the foot whereby the toes are flexed downwards.

POLYMORPHOUS PERVERT. One who exhibits the pregenital phases of sexuality, natural in infants, including oral and anal eroticism, sadism, exhibitionism, etc.

PRE-CONSCIOUS. That portion of consciousness which is not in focus but the contents of which can be recalled at will.

PRE-FRONTAL LEUCOTOMY. The operation of severing the white nerve fibres which connect the frontal lobes of the brain with the basal ganglia, etc.

PRE-GENITAL SEXUALITY. The infantile organisation of the sexual pattern in which the component instincts and the pre-genital erotogenic zones, such as oral, anal and phallic, are absorbing the greater part of the libido.

PROGNOSIS. Prediction. (Medicine): foretelling the course or results of an illness or condition.

PROJECTION. The attributing to persons or things outside oneself of mental processes, affects, etc., that originated within one's own mind (and have been repressed), with relief of tension; common in varying degrees to all minds, with consequent impairment of their reality appreciation. It is very characteristic of paranoia. (Cf. INTROJECTION.)

PROPHYLACTIC. Preventative. Prophylaxis is the measures adopted to prevent disease.

PSYCHE. Mind.

PSYCHIATRY. That branch of medical science which deals with mental diseases and disorders.

PSYCHO ANALYSIS (1) A technical method introduced by Freud of bringing unconscious conflicts, complexes, etc., into consciousness by the process of free association of thought, dream analysis and interpretation of the transference situation (2) The body of knowledge so obtained, including its theoretical interpretation

PSYCHO BIOLOGY A term invented by A. Myer to designate his conception of mental disorder as a biological phenomenon, that is to say as the product of the morbid reaction of the organism as a whole to its environment. If this concept of morbid reaction as the determining factor in mental disorder were held to include a Lamarckian like inheritable quality throughout a succession of generations, it would, in my opinion, fit the observed facts more adequately.

PSYCHOGENIC Originating in the mind

PSYCHONEUROSIS Psychogenic illness (*i.e.* without organic cause) characterised by derangement of the normal ways of gratification of the libido due to unconscious conflict, and, while leaving the ego or reason relatively unimpaired (cf. **Psychosis**), giving rise to a variety of symptoms and pathological states which are amenable to psychotherapy

PSYCHOPATHOLOGY The study of morbidity in the psyche

PSYCHOSIS Insanity Mental illness which includes the ego or reason and therefore the person's relationship to reality (Cf. **Psychoneurosis**)

PSYCHOTHERAPY The treatment of psychoneurotic, characterological and psychotic disorders by psychological methods, usually one of the forms of mind analysis, or by explanation, persuasion, re-education, relaxation, suggestion, hypnosis, vegetotherapy (Reich) or by occupational therapy

PYKNIC TYPE Short, stocky, plump people, with rather short and thick necks, were termed by Kretschmer as belonging to his Pyknic type, as he found that the majority of those suffering from manic depressive psychosis had this physical configuration, whereas the majority of schizophrenics belonged to his 'Aesthenic' or 'Athletic' types

RATIONALISATION The attributing of reasons for judgments, ideas or actions which are otherwise (usually emotionally) determined

REACTION FORMATION A character trait, or its development, unconsciously designed to hold in check, conceal or contradict a tendency of an opposite kind. Thus obsessional cleanliness would be a reaction formation against repressed dirtying tendencies. Disgust, shame and morality are other reaction formations

REGRESSION The reversal of the normal direction of the libidinal stream so that early infantile stages of its development (fixation points) are reactivated

REPRESSION The rejection from consciousness, by an unconscious mechanism, of mental material, concepts and affects, which are unwelcome. Analysis has shown that this material remains active, and dynamic in the unconscious, that the expenditure of repressing energy continues and that the repressed commonly re-emerges in altered forms such as symptoms

RETROBULBAR NEURITIS Inflammation of the optic nerve behind the eyeball

SADISM. The achievement of erotic pleasure by victimising the sexual object, commonly by inflicting helplessness or pain upon him.

SCHIZOPHRENIA. Split mind. A psychosis, usually in early life, characterised by repressed affect and interest with introversion and progressive dementia.

SCREEN MEMORIES. Memories which by carrying the affects of some earlier experience serve to relieve to some extent the tension of that experience and thereby to cover, or inhibit, its emergence into consciousness.

SEX-FUGAL. A word coined to designate the concept of movement of the libido or interest away from sexuality; usually instigated by anxiety.

SIMMONDS' PITUITARY CACHEXIA. A rare condition of feebleness, wasting, loss of hair, impotence and premature senility due to disease, atrophy, or destruction of the pituitary gland.

SKOTOMISATION. A condition in which the individual denies everything which conflicts with his ego, even to the extent of self-punishment for hatred of another, or, on a mental plane, of producing, through repression, "areas" of mental "blindness". (The Skoptsy, a religious sect, practised actual castration for the kingdom of Heaven's sake.)

SOMATIC CONVERSION. The conversion of emotional energy, usually hysterical, into physical or bodily symptoms.

SOPOR. Torpor. The term "sopor" is used to designate a condition between that of hypoglycaemia (insulin-induced) and coma. There is loss of normal response to questioning but not total loss of all response.

STATUS EPILEPTICUS. A condition in which a succession of epileptic fits occur without interruption.

STILBOESTROL. A synthetic product corresponding chemically, and practically identical therapeutically, with oestrone, the hormone of the ovarian pregnancy follicle. It is used especially to retard the process of menopausal involution.

STRAMONIUM. The dried leaves of *Datura stramonium*. From these various extracts and tinctures are prepared containing the alkaloid hyoscyamine with a little atropine and hyoscine.

SUBLIMATION. The process of deflecting libido from sexual aims to interests of a non-sexual and socially approved nature.

SUPER-EGO. That part of the mental apparatus developed in early life by the mechanism of repressing frustrated impulses, such as aggression, and projecting them on the frustrators and subsequently introjecting them. Its function is largely to oppose the id, often unreasonably, and even to criticise and punish the ego if it tends to accept id demands. It is a sort of primitive unconscious conscience.

SUPER-EGO RESISTANCE. Resistance to analytical progress and insight emanating from the super-ego and due to the rigidity of the latter's formation. For instance, moral or religious values early implanted do not readily yield to the impingement of a more recently acquired reasoning. Nevertheless, though super-ego resistance is usually the first resistance encountered during analytical work, modification of the super-ego in the light of reason is usually the first-fruits of analytical progress.

SYMPTOMATOLOGY. The study of symptoms, usually of the specific disease or syndrome under consideration.

SYNDROME A group of symptoms or signs which are found together and appear to form a clinical entity, but which, in the absence of the discovery of a common underlying cause, cannot be held to constitute a disease entity

TALION PUNISHMENT Retaliatory punishment Punishment equivalent to the crime The principle of "eye for eye, tooth for tooth"

THYRODECTOMY The surgical removal of the thyroid gland

THYROID A vascular gland consisting of two lateral lobes either side of the larynx connected by a narrow isthmus When enlarged it is visible, as in goitre It produces an internal ductless colloid substance which is absorbed into the lymphatic and blood systems The active principle of this colloid substance is thyrotoxine (See below)

THYROTOXINE The active principle of the colloidal secretion of the thyroid gland It exerts a profound influence upon the development and metabolism of the body (See under CRETINISM and MYXEDEMA)

TORTICOLLIS Wry neck, due to the contraction or spasm of muscle Spasmodic torticollis is a nervous disorder which exhibits contortion or intermittent contraction of the muscles on one or both sides of the neck, the head being jerked to one or other side or backwards It can be an hysterical phenomenon or a tic

TRANSFERENCE A displacement of any affect from one person to another Specifically during analysis the affects originally felt during infancy for the parents become unconsciously displaced on to the person of the analyst so that the analysand feels towards him unjustifiable love and hate and has no insight into the phenomenon and its irrelevance

TRANSFERENCE RESISTANCE The resistance which an analysand exhibits to the normal analytical process of transferring his infant parent affects on to the image of his analyst At the same time it should be borne in mind that the phenomenon of transference is itself a resistance to the memories of the childhood emotions which were originally experienced during the Oedipus situation

TRAUMA A morbid condition produced by an unpleasant experience

TRIGEMINAL NEURALGIA Tic douloureux Neuralgia (pain) in one or more of the three branches of the trigeminal or fifth cranial nerve The sensory branches of this nerve supply the skin over the forehead and front of the scalp, around the eye, the cheek, the upper and lower jaws, the teeth, tongue and the interior of the mouth and throat The pain can be incredibly severe, sometimes causing a spasm of muscles in the affected region It is usually psychoneurotic in origin

TUMESCENCE A swelling up Specifically the turgidity produced in the sexual organs during the pre orgasm stage of sexual excitement

UNCONSCIOUS A region of the psyche which contains mental processes and constellations which are ordinarily inaccessible to consciousness, commonly owing to the process of repression The technique of mind analysis is especially designed to bring this unconscious material into consciousness by overcoming the resistances and repressing forces, as it is from the unconscious conflicts or complexes and their opposing forces or reaction formations that all symptoms emanate

URETHRAL EROTISM. Erotic feelings produced by stimulation of the urethra (the urinary passage from the bladder to the exterior) during the passage of urine. It is one of the components of the genital sexual instinct.

VITAMIN. The term applied to substances which occur in minute quantities in natural foods and which are essential for growth and normal metabolism and the maintenance of health. The absence of one or more of them gives rise to deficiency diseases, remediable by their administration.

WERNICKE'S SYNDROME. In 1881 Wernicke described a symptom complex which included (1) disturbances of the higher mental functions, such as memory and consciousness, sometimes progressing to confusion, hallucinations, delusions, confabulations, delirium and death; and (2) neurological signs and symptoms, such as disturbances of eye movements and pupils and peripheral neuritis. He thought it was due to haemorrhagic inflammation of the hypothalamus of the brain caused by alcoholism, but it is now held to be predominantly due to deficiency of vitamin B₁ and perhaps of nicotinic acid.

WHOLE-OBJECTS. The person as a whole, in contradistinction to exclusive interest in some anatomical part. (Cf. PART OBJECTS.)

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